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COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

September 22, 2005

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

SUBJECT: **UPDATE ON THE STATUS OF DREW UNIVERSITY AND THE AFFILIATION AGREEMENT**

In the past several months, your Board has approved several motions requesting additional information and analysis about the performance of Drew University and its fitness to meet expectations of the Medical School Operating Agreement (MSOA). These motions have requested:

1) An analysis of the Drew University's Annual Report with specific recommendations.
2) Detail on efforts to increase accountability measures.

Analysis of Drew University's Annual Report on Graduate Medical Education and a year-end evaluation of performance under the MSOA

The Department's quarterly analysis and annual review of the contract can be found in Appendix A. Drew University's Annual Report, and Accreditation Council of Graduate Medical Education (ACGME) Site Visit Corrective Action Work Plan can be found in Appendix B.

Annual Report Summary Findings

1) The Annual Report, when combined with the ACGME Site Visit Corrective Action Work Plan, meets contract reporting requirements; it is complete and was received in advance of the required submission date of August 15. This year's Annual Report is substantially improved over the previous year's report which was incomplete, late and out of compliance with contract requirements.

2) Future Annual Reports should combine these documents into a single summary.

The Annual Report taken alone is still written as historical narrative rather than a critical summary of training program specific and overall Graduate Medical Education (GME) performance. It is important to note that the current GME leadership started after the close of the academic year covered in this Annual Report and as a result, it is difficult for the staff to provide more than a historical narrative. When the Annual Report is combined with the ACGME Site Visit Corrective Action Work Plan, the appropriate level of problem identification, corrective action and tracking to resolution is evident. Since the change in University leadership, the Department has participated in regular GME leadership planning meetings with the University and King/Drew Medical Center (KDMC) staff. The University and KDMC are working together to address the issues in the ACGME Site Visit Corrective Action Work Plan.

Contract Monitoring Summary Findings

1) Drew University's compliance with MSOA requirements improved over the three quarters covered in the first contract year of the current MSOA.
2) At the beginning of this contract, the University did not have adequate fiscal, administrative or educational oversight in place, which led to multiple failures in meeting reporting requirements, and little evidence of appropriate reconciliation of academic and clinical hours. These weaknesses improved progressively over the three quarters. These improvements appear to be sustained and enhanced since July 1, 2005 as a result of leadership changes made by the University.
3) While substantial improvements have been made, there are still critical performance requirements in the contract, such as the creation of criteria for the award of faculty stipends that have yet to be developed and/or fully implemented.
4) At your Board's direction, the Department added significant rigidity to the hourly monitoring and fiscal aspects of the MSOA. Specifically, the requirement that a forty hour academic unit (unit or work measurement in the MSOA) can be provided by only one individual, while conceptually appropriate as a fiscal restraint, has in reality been difficult to implement while not necessarily incentivizing the right outcome – appropriate academic work by the appropriate individual for the appropriate amount of time to meet ACGME requirements. The Department recommends amending the contract to allow hourly reimbursement within academic units.

Efforts to Increase Accountability Measures

The Department acknowledges that accountability is a two-way street and that KDMC has had its own problems with accountability. Since January, the Department has opened more than 660 personnel cases (approaching twenty-five percent of the Work Force) resulting in more than 100 dismissals, including a number of physicians. The Department has taken the following actions to increase accountability at KDMC:

- Reconstitution of KDMC's executive management staff, most notably the hiring of a new CEO, Ms. Antionette Smith-Epps.
- The hiring of a new permanent Director of Human Resources at KDMC, Mr. Phil Rocha, who started September 6, 2005.

- Training was provided to all physician leaders at KDMC on core management skills in human resources. This training has been completed and additional training will be provided as necessary.
- Rewriting of physician services agreements to clarify how they are used and to formalize monitoring and accountability requirements. Medical Directors of all the facilities have received summary training on these contracts and all service chiefs in all the hospitals will be required to go through mandatory training. This training is scheduled to be completed in the next 45 days.
- Implementation of a more comprehensive Department level physician contract monitoring oversight program.

The new leadership at Drew University has also made headway in increasing accountability. These efforts are significant given that they have only been place slightly more than two months. These efforts include:

- A thorough review of all the training programs and an initial blueprint for the future.
- Implementation of a thoughtful program to prepare for the ACGME site visit in December.
- A proposal to move all physicians to one-year contracts. The new Provost of the University took his position on a one-year contract as a way of leading by example.
- Meaningful efforts are underway to recruit a permanent Dean and some of the critical unfilled Department Chairs are close to being filled.

While these efforts are critical first steps, not enough time has passed to assess the completeness of their implementation or the effectiveness of their outcomes. To date Drew has not demonstrated evidence of an adequate comprehensive physician evaluation process. A regular (usually annual) rigorous evaluation of all aspects of academic work is a critical part of every medical school's faculty assessment of suitability for academic promotion. Academic title and salary stipends are directly tied to these evaluations. The Department strongly supports the University's plan to move to one-year contracts, but Drew has not yet reported how many physicians have been transitioned to such agreements. Finally, the University has yet to develop academic criteria for receiving stipends and then reconcile these criteria across the current array of stipends to ensure that individuals are compensated appropriately.

The Department endorses the majority but not all of Drew University's recommendations about its residency programs (Appendix C). KDMC is not a tertiary care hospital and will not become one in the foreseeable future. KDMC does not have the appropriate patient volume or mix to meaningfully support residency training in a number of areas. The current breadth of training programs proposed by the University is still too broad to be supported by an academic community hospital. The Department acknowledges that some of these training programs may seem central to meeting Drew University's efforts to become a full four-year medical school. If this is the case it will be incumbent upon the University to develop strategic relationships with other hospitals that actually see large volumes of these patients. Both UCLA and USC have a wide variety of academic affiliations with local medical centers and Drew University needs to develop similar sorts of relationships to meet their educational mission. The Department would support bridge funding for a period of time for those programs that might be financially transitioned, in whole or in part, to other hospitals. The Department believes the following programs need to be revisited:

1) Pediatrics and Obstetrics and Gynecology – The lack of patient volume threatens the future of these programs. The Department has recommended to your Board the closure of inpatient pediatrics and all of obstetrics in an effort to stabilize the hospital prior to the Centers for Medicare and Medicaid Services (CMS) Full Conditions of Participation Survey. The Department has also recommended the expansion of outpatient pediatric services and the continuation of gynecology services. Whether or not your Board moves forward with these recommendations, Drew University must find permanent strategic partners for the inpatient components of these training programs if they are to survive. If your Board does implement the proposed refocusing of these services, the Department would still recommend supporting resident activities in outpatient pediatrics and full scope gynecology.

2) At your Board's direction, the Department is actively exploring contracts with private physician groups to provide anesthesia, radiology, intensive care and emergency department services. Currently Drew University offers training programs in emergency medicine and anesthesia; the radiology program had its accreditation withdrawn last year. It is possible that a private medical group might be interested in running these clinical programs without the involvement of residents.

3) Many of the surgical and medical subspecialties programs are extremely small with only a few residents or fellows. It may make sense for these programs to be merged or integrated with similar training programs at UCLA, USC, private hospitals or other County facilities. Some of the larger but relatively weak programs, such as Family Medicine, might also benefit from a merged or integrated relationship.

4) The Orthopedics Program has faced significant ACGME accreditation challenges and its future needs to be reviewed.

Summary

Despite the challenges and unanswered questions that remain, the Department believes that Drew University continues to makes substantial and substantive progress. Based on efforts over the past two months, the University is working diligently to prepare for the ACGME site visit in January and that the new leadership is focused on appropriate structural reforms.

Recommendations

1) Plan on allowing KDMC to participate in the national residency match this winter.
2) Direct County Counsel to work with the Department to amend the current MSOA to allow increased flexibility with appropriate monitoring for both clinical and academic work.
3) If both the ACGME Institutional Review and CMS Full Conditions of Participation survey have positive outcomes, direct County Counsel and the Department to negotiate a one-year extension of the MSOA with Drew University. Any additional flexibility or change in structure would be based on the University's performance over the next year. To assess the University's progress the Department recommends:

    - Continued monitoring of all elements of the MSOA for full compliance.

- A written plan with monthly updates on the status of President, Dean and Department Chair Searches.
- Monthly updates on the ACGME Site Visit Corrective Action Work Plan.
- Within 60 days, development and joint approval of a standardized set of criteria for the award of faculty level stipends consistent with MSOA requirements. Completion of an analysis, reconciliation, and appropriate adjustments if necessary to the current stipend structure.
- Within 60 days, development of a written program to convert faculty to one-year contracts, with the development of the contracts to include criteria for annual evaluation and renewal. Evidence of implementation to include monthly updates by clinical department of the number and percent of faculty receiving stipends that have been converted to one-year contracts.
- Within 60 days, development of a formal academic evaluation process to assess suitability for retention of academic title and promotion. Provide evidence that all faculty have had a completed academic evaluation under the terms of this new program prior to the beginning of contract negotiations for the one-year extension.
- Within 60 days, development and implementation of appropriate Human Resources processes within the University to approve and track offsite work consistent with County and Drew University policies.
- By November 8, provide an update to the internal plans for specific residencies, pending the results of upcoming Residency Review Committee site visits and changes in the clinical program currently under consideration by your Board. This update should include information about strategic partners and their financial contributions to specific residency programs. This update should specifically outline any mergers, integrations, downsizings or closures of training programs consistent with the hospital's clinical program, patient mix and volume patterns.

Please contact me if you have any questions or concerns.

TLG:bc

Attachments

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

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COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
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September 20, 2005

Dr. Thomas T. Yoshikawa
Provost-Chief Operating Officer/Acting President
Charles R. Drew University of Medicine and Science
1731 East 120TH Street
Los Angeles, California 90059

SUBJECT: **DREW UNIVERSITY'S ANNUAL REPORT ON GRADUATE MEDICAL EDUCATION**

Dear Tom:

This correspondence is written in response to the submission of the 2004-05 "Annual Report of the Graduate Medical Education Committee" and the 2005-06 "Graduate Medical Education Plan of Correction". Taken together the submission of both reports was timely and the content compliant with the contract requirements. This represents a tremendous effort that is recognized and appreciated by this office. There are some opportunities for improvement in both reports and suggestions have been made for future reporting.

2004-2005 "Annual Report on Graduate Medical Education" (GME)

The Annual Report on GME summarizes graduate medical education (GME) activities as administered by Drew University from July 1, 2004 to June 30, 2005 and meets the reporting requirements identified in section 8.2.4.2.5 "Annual Report" of the medical school Affiliation Agreement between Drew University and Los Angeles County.

The membership of the Drew University Board of Trustees changed significantly during the academic year and it is recognized that their work resulted in the appointment of a new President, Interim Dean and Designated Institutional Officer (DIO). Dr. Nancy Hanna appointed as DIO on July 1, 2005 coordinated the timely submission of the Annual Report on GME to this office a month

later. The Annual Report, based on the information gathered by the previous GME administration, is comprehensive and provides an overview of the graduate medical educational activities for the academic year 2004-2005. It provides an overview of the accreditation status of the institution and all Drew and County (General Dentistry and Oral Maxillofacial Surgery) training programs as of June 30, 2005. Identified are the institutional problems common to all training programs and the corrective action taken or proposed. The Annual Report identifies leadership changes in GME, provides a clear description of the role and responsibilities of the GMEC and summarizes faculty academic achievements.

The Annual Report would be strengthened by the inclusion of an executive summary that comments on the educational goals achieved and identifies University management's focus and priorities for the 2005-06 academic year.

2005-2006 "Graduate Medical Education Plan of Correction"

In accordance with Section 2.6.1 of the Affiliation Agreement and for the purpose of determining the institution's readiness for achieving full accreditation prior to the ACGME Institutional Review scheduled for January 2006. The Department requested that the University submit a plan for correcting program and institutional deficiencies. Dr Hanna submitted the 2005-06 GME Plan of Correction that describes in detail the citations and concerns as presented by the Accreditation Council on Graduate Medical Education (ACGME) and the American Dental Association (ADA), and the results of corrective action taken by the University. The report identifies the month and year in which future corrective action is targeted for completion and identifies the department and/or manager accountable for monitoring the plan. Dr. Hanna also provided a separate timeline that summarizes the GME activities that must be completed in preparation for the Institutional Review. Both reports are comprehensive in their scope.

DHS recognizes that the current leadership took control over GME just as the academic year reviewed in this report had ended. With this in mind, there are several areas that could be improved and these suggestions should be considered in future reports. Annual reports would benefit from an executive summary highlighting key accomplishments, challenges, and goals for the next year. Future reporting formats would also benefit from the integration of institutional and program-specific reviews to be accomplished by including elements of the Plan of Correction into the body of the Annual Report.

The GME Plan of Correction would be improved by stating more clearly where the University has not formulated a specific plan. In some instances the University provided, as substitute for a plan of corrective action, a description of existing management practices, or a statement updating the existing problem. It appears that some matters reported as "corrected" by the University are still unresolved (e.g. resident information system implementation). The report would be enhanced, in some instances, by more specific target dates that match the described action plan.

Overall, the Office of Graduate Medical Education is to be commended for compiling such an expansive report in so short a time. I recommend that regular updates of this report be submitted to this office, using the same reporting format, until the date of the ACGME inspection. Future reports should account for any discrepancies in the previous report.

If you have any questions or need additional information, please contact me.

Sincerely,

Bruce Chernof, M.D.
Senior Medical Director
Office of Clinical Affairs and Affiliations

BC:ll

c: Thomas L. Garthwaite, M.D.
Roger Peeks, M.D.
Ron Edelstein, M.D.
Nancy Hanna, M.D.
Lewis Lewis

Contract Monitoring Executive Summary
Fiscal Year 2004-05
October 1, 2004 through June 30, 2005

Affiliation Agreement Between
Los Angeles County King/Drew Medical Center and
C.R. Drew University - #75086

Monitoring Method

Policy, financial and administrative practice compliance is evaluated on an ongoing basis and scored quarterly to assess the University's performance with contractual obligations and to promote accountability. After the final day of monitoring, the first day of the end of the contract quarter, the University is granted a 45-day grace period to comply with contract deliverables. The Office of Clinical Affairs and Affiliations systematically monitors information submitted by University staff and other accountable parties for timeliness, accuracy with qualification and completeness. As the grace period expires, the "Contract Monitoring Summary Report" is drafted for recommendation and validation.

The Contract Monitoring Summary Report is a standardized reading form, developed to ensure consistent information reporting. Each report contains the following reporting elements:

- Review date
- Contract provisions (Boilerplate, Addenda A and B)
- Description of noncompliant area(s)
- Accountable Management
- Penalties, when applicable, for general noncompliance, Sanctions, and Contract Reductions
- Overall quarter percentage of compliance

Performance Scoring

The Department has developed an internal scoring tool to evaluate and benchmark performance against contract requirements. Based on quarterly monitoring outcome, an overall final score (percentage of compliance) is awarded. 97 total points is the highest possible award. Penalty points for noncompliance are subtracted from the maximum point total as follows:

Compliance				Noncompliance (- points each occurrence)			
Maximum Points Awarded	Boilerplate	41	(+1 pt ea)	Penalties	Boilerplate -1	Recurring breach	-1
	Addendum A	8	(+2 pts ea)		Addendum A -2	Recurring breach	-2
	Addendum B	8	(+2 pts ea)		Addendum B -2	Recurring breach	-2
	Sanctions (not levied)	40	(+5 pts ea)		Sanctions -5		
		97			Contract Reduction (Addendum A) -5		

The bar chart below depicts overall compliance percentages, by quarter, with an average compliance rate of 78% for fiscal year 2004-05.

Fiscal Year Review
Areas of Noncompliance

• 1st Contract Quarter

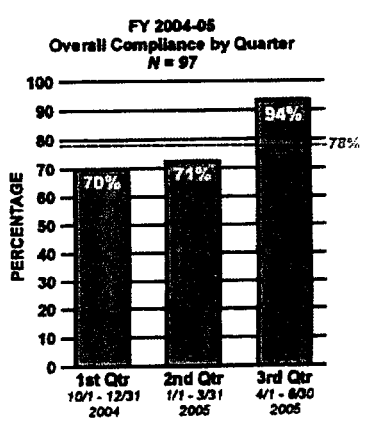
Sanctions totaling $21,000.00 were imposed for the University's failure to provide required contract documentation in Addendum B sections: B.2.2-Educational Performance Indicators; B.3.4-Physician Staffing Levels and Compensation; and B.4-Communication and Information Sharing. The University was also cited for noncompliance in two areas of boilerplate section 2.0-Responsibilities of the University and one area in boilerplate section 8.0-Joint Planning and Operations Committees. The sanctions were levied on May 1, 2005, during the third contract quarter.

• 2nd Contract Quarter

From October, 2004 through February, 2005, the County reported variances in the required number of academic and clinical purchased service hours (6,926.0). Clinical purchased services are as-needed services, therefore the University was not cited for breach. The University was cited for failure to provide 176.0 hours of academic purchased services (A.4-Academinc Purchased Services).

A $1,000.00 sanction was levied in the third contract quarter, for a first quarter recurring breach in Addendum B: B.3.4-Physician Staffing and Compensation.

Two areas in boilerplate section 2.0-Responsibilities of the University, and section 8.0-Joint Planning and Operations Committees were cited as breaches recurring from the first quarter. The final citation; Addendum B, section B.4-Communication and Information Sharing, was imposed due to the University's failure to provide ACGME-related correspondence.



Executive Summary - Fiscal Year 2004-05 *page2*

• 3rd Contract Quarter

The County conducted a comprehensive reconciliation of all billable hours for the time periods from October 1, 2004 through February, 2005. The variance in purchased service hours was reported by the County in March, 2005. Second quarter contract reductions (recoupments) totaling $935,531.00 ($300,000.00 levied on May 1, 2005 and $635,531.00 levied on June 1, 2005) were the result of University's failure to provide 6,926.0 hours of academic and clinical purchased services (Addendum A). Contract requirements related to these reductions are: A.3-Clinical Purchased Services and, A.4-Academic Purchased Services.

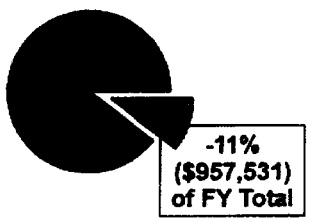
Citations resulted in boilerplate sections: 4.0-Joint Responsibilities and, 9.0-Reporting and Accountability. There was one recurring second quarter breach of Addendum B: B.4-Communication and Information Sharing. The University failed to provide ACGME-related correspondence.

Financial Report

The fiscal year 2004-05 operating budget was $9,028,114.00. During the third contract quarter, the University lost 11% ($957,531.00) of its total fiscal year budget. This represents a 32% revenue loss for the third contract quarter.

County recoupments were levied as follows:

Action	Imposed	Levied	Penalty
Sanctions	Ist contract qtr	May 1, 2005	$21,000.00
Contract Reduction	2nd contract qtr	May 1, 2005	$300,000.00
Contract Reduction	2nd contract qtr	June 1, 2005	$635,531.00
Sanction	2nd contract qtr	June 21, 2005	$1,000.00



General Recommendations

1. Continued communication between the County and the University with evidence of collaborative efforts to correct deficiencies
2. Continued focus on report and deliverable development with timely reporting mechanisms
3. Improved data collection for reporting accuracy
4. Continued attention to contract requirements
5. Monthly/frequent monitoring in all areas by accountable management to achieve/ maintain compliance

Affiliation Agreement Between
Los Angeles County King/Drew Medical Center and
C.R. Drew University - #75086

Contract Monitoring Summary Report

Contract Quarter: *1st QTR (Oct 1 - Dec 31, 2004)*

DATE: *April 4, 2005*

Summary Report of Non-compliance ☑:

Section I. General Contract Provisions (Boilerplate)	Contract Section(s)	Description of non-compliant area(s)	Accountable Mgmt
☑ 2. Responsibilities of University	*2.6.1. and 2.6.3.*	*See descriptions below*	*S. Ashley/M. Willock*
☐ 3. Responsibilities of County			
☐ 4. Joint Responsibilities			
☐ 5. Purchased Services			
☐ 6. Payment for Purchased Services			
☑ 8. Joint Planning & Ops Committees	*8.2.4.2.5.*	*Annual Report description below*	*M. Willock*
☐ 9. Reporting & Accountability			

Section II. Addendum A Contracted Services:	Documented Hours	Verified Hours	Variance	Accountable Mgmt
☐ A.2.1. Clinical Services		*YES*		*R. Peeks/R. Lau*
☐ A.2.2. Academic Services	*YES*	*YES*		*R. Peeks/R. Lau*
☐ A.3. Purchased Clinical Services		*YES*	*NO*	*R. Peeks/R. Lau*
☐ A.4. Purchased Academic Services		*YES*	*NO*	*R. Peeks/R. Lau*

Percentage of non-compliance w/ documented hours: *0* %

Percentage of non-compliance w/ verified hours: *0* %

Total hour variance Purchased Clinical Services: *0* Purchased Academic Services: *0*

Section III. Addendum B Contracted Services:	Description of non-compliant area(s)	Sanction Amount	Sanction N/A	Accountable Mgmt
☑ B.2. Academic Performance	*B.2.2. description below*	*$10,000*		*S. Ashley/M. Willock*
☐ B.3. Patient Care Performance Improvements			N/A	
☑ B.3.4. Physician Staffing and Compensation	*B.3.4. description below*	*$1,000*		*S. Ashley*
☑ B.4. Communication and Information Sharing	*B.4. description below*	*$10,000*		*M. Willock*

Sanction amount: $ *21,000* Date Levied *May 1, 2005* Percentage of monthly contract amount: *2.09* %

Description of compliance issues:

2.6.1. Accreditation of County & University Training Programs

- *University failed to provide workplans for ending "Probationary Accreditation" status for Anesthesiology, Family Medicine, the Institution AND the "Proposed Probation" status for Ortho Surgery*
- *University failed to provide monthly progress reports on efforts to correct probationary program status*

2.6.3. Academic Administration & Supervision of County Training Programs

- *GME office failed to provide, by program, all current County Housestaff and facilities through which County Housestaff rotate*

8.2.4.2.5. Annual Report

- *Submitted report was non-compliant with contract requirements. University failed to provide corrected report*

B.2.2. Educational Performance Indicators

- *Failure to submit Summary Report of Internal Reviews for Family Medicine (11/17/04) and Ortho Surgery (12/17/04)- Sanction levied at $10,000 ($5,000 each occurrence)*

Description of compliance issues: ***page 2***

B.3.4. Physician Staffing Levels...

- *Failure to submit quarterly report at JPOC meeting regarding County Housestaff numbers and approved ACGME positions.*
  Sanction levied at $1,000

B.4. Communication and Information Sharing

- *Failure to submit quarterly report at JPOC meeting listing ACGME correspondence; dates, significant findings, citations, etc.*
  Sanction levied at $10,000

Overall quarter compliance percentage: *70%* *(N=97)*

Affiliation Agreement Between
Los Angeles County King/Drew Medical Center and
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Contract Monitoring Summary Report

Contract Quarter: *2nd QTR (Jan 1 - Mar 31,2005)*

DATE: *May 16, 2005*
Summary Report of Non-compliance ☑ :

Section I. General Contract Provisions (Boilerplate)	Contract Section(s)	Description of non-compliant area(s)	Accountable Mgmt
☑ 2. Responsibilities of University	*2.6.1. and 2.6.3.*	*See descriptions below & pg 2*	*S. Ashley/M. Willock*
☐ 3. Responsibilities of County			
☐ 4. Joint Responsibilities			
☐ 5. Purchased Services			
☐ 6. Payment for Purchased Services			
☑ 8. Joint Planning & Ops Committees	*8.2.4.2.5.*	*Annual Report, pg 2*	*M. Willock*
☐ 9. Reporting & Accountability			

Section II. Addendum A Contracted Services:	Documented Hours	Verified Hours	Variance	Accountable Mgmt
☐ A.2.1. Clinical Services	N/A	*YES*	N/A	*R. Peeks/R. Lau*
☐ A.2.2. Academic Services	*YES*	*YES*	N/A	*R. Peeks/R. Lau*
* ☑ A.3. Purchased Clinical Services	N/A	*YES*	*YES*	*R. Peeks/R. Lau*
☑ A.4. Purchased Academic Services	N/A	*YES*	*YES*	*R. Peeks/R. Lau*

Percentage of non-compliance w/ documented hours: *0* %

Percentage of non-compliance w/ verified hours *0* %

Variance hours for Purchased Services from October, 2004 through February, 2005.
See Table I

Total hour variance Purchased Clinical Services: *(6,750.0)* * Purchased Academic Services: *(176.0)*

Contract reduction: $ *300,000.00* Date Deducted *May 1, 2005* Percentage of monthly contract amount: *29.9* %

Contract reduction: $ *635,531.00* Date Deducted *June 1, 2005* Percentage of monthly contract amount: *63.4* %

Section III. Addendum B Contracted Services:	Description of non-compliant area(s)	Sanction Amount	Sanction N/A	Accountable Mgmt
☐ B.2. Academic Performance				
☐ B.3. Patient Care Performance Improvements			N/A	
☑ B.3.4. Physician Staffing and Compensation	*B.3.4. description on pg 2*	*1,000*		*S. Ashley*
☑ B.4. Communication and Information Sharing	*B.4. description on pg 2*			*S. Ashley/M. Willock*

Sanction amount: $ *1,000* Date Levied *June 21, 2005* Percentage of monthly contract amount: *0.10* %

Description of compliance issues:

2.6.1. Accreditation of County & University Training Programs

- *University failed to provide workplans for ending "Probationary Accreditation" status for Anesthesiology, Family Medicine, Ortho Surgery and the Institution. The University provided no information in the 1st quarter. Continued failure to provide such information constitutes a recurring breach for this contract quarter*

Description of compliance issues: ***page 2***

2.6.3. Academic Administration & Supervision of County Training Programs

- *GME office failed to provide, by program, all current County Housestaff and facilities through which County Housestaff rotate. The GME office provided no information in the 1st quarter. Continued failure to provide such information constitutes a recurring breach for this contract quarter*

8.2.4.2.5. Annual Report

- *Submitted report was incomplete. The report covers July-December, 2004 and is a general status report of GME activity. The University failed to provide prescribed report in the 1st contract quarter. Continued failure to provide an accurate, complete report constitutes a recurring breach for this contract quarter*

A.4. Academic Purchased Services

- *From October 2004, through February 2005, the University failed to provide 176 hours of Purchased Academic Services creating a 20% variance. See Table I*

B.3.4. Physician Staffing Levels...

The Agreement mandates the provision of quarterly, accurate written reports on Housestaff totals by specialty and subspecialty.

- *The University provided an overall resident count with no breakdown by speciality/subspecialty. The University provided no information in the 1st contract quarter. Continued failure to provide the requested information constitutes a recurring, sanctionable breach for this contract quarter. ($1,000.00 Sanction)*

B.4. Communication and Information Sharing

The Agreement states that the University shall provide all ACGME, RRC and IRC... correspondence to the Director of Health Services on the day such correspondence was received...

- *The University failed to provide the following correspondence: See Table III*

Description of variance in as-needed Clinical Purchased Services:

*Important to NOTE:
The following contract section, based on as-needed services, is cited but does not constitute breach. The University was not penalized.
See page 1, Section II for contract reduction totals.

A.3. Clinical Purchased Services

The agreement states that the University shall provide no fewer than those hours set forth in the specialty areas...

- *From October 2004, through February 2005, the University did not provide 6,750.0 hours of Purchased Clinical Services creating a 42% variance. See Table II*

Overall quarter compliance percentage: 71% *(N=97)*

Attachment

Attachment I
(2nd Quarter, January 1- March 31, 2005)

Addendum A

Table I

Note: There were no variances reported in the first contract contract quarter

Documented Hours October, 2004 - February, 2005 reported in this contract quarter	Target Hours	Actual Hours	Hours Under	Total Variance
Purchased Clinical Services	16,095.0	9,345.0	6,750.0 (42%)	6,926.0
Purchased Academic Services	887.5	711.5	176.0 (20%)	

Note: The County will reduce the May 2005 monthly payment by $300,000.00 contingent upon performance by the University of a comprehensive analysis and reconciliation of all claimable hours and units for the time period of October 1, 2004 through April, 2005. If the analysis, due May 20, discloses that the County's recoupment was unnecessary or should be smaller, the June payment to the University will be adjusted. If the analysis discloses that additional recoupments are necessary, additional recovery by the County will be effected with the June 2005 payment (See attached memo from Roger Peeks, Medical Director KDMC, dated May 5, 2005)

Table II

Purchased Clinical Services
October, 2004 - February, 2005

Services	Target Hours	Actual Hours	Variance
Anesthesiology	3,915	101	(3,814)
Neuro	1,740	0	(1,740)
Ophthalmology	1,915	719	(1,197)
Urgent Care	7,830	7,830	0
Vascular	695	695	0
			(6,750)

A.3. 42% variance for budgeted contract hours

Table III

DATE	FROM	TO	SUBJECT
10/29/04	DIO	Ortho RRC	New Program Director
10/29/04	Ortho PD	Ortho RRC	Response to adverse status
11/03/04	Int Med RRC	Endocrin PD	Commendation without citation
11/03/04	Int Med RRC	Gastro PD	Commendation of substantial compliance
11/03/04	Int Med RRC	Inf Disease PD	Commendation without citation
11/03/04	Int Med RRC	Geriatrics PD	Commendation without citation
11/19/04	Ortho RRC	Ortho PD	Confirmation of site visit 03/08/05
11/23/04	Derm RRC	Derm PD	Notice of site visitor change
12/01/04	ENT PD	ENT RRC	Prog Rpt in response to 09/30/04 letter
12/27/04	Ophthal PD	Ophthal RRC	Request for temporary compliment in 04-05 academic year
01/02/05	Ortho PD	Ortho RRC	Agenda for 03/08/05 site visit
01/10/05	Psych RRC	Psychiatry PD	Acknowledged receipt of 08/24/04 prog rpt
01/13/05	DIO	IRC Exec Dir	JCAHO and initial appeals
01/14/05	Ortho RRC	Ortho PD	Probationary Accreditation
01/25/05	ENT RRC	ENT PD	NO SUBJECT SPECIFIED
01/28/05	IRC	DIO	Acknowledged receipt of 01/13/05 letter
02/01/05	Ophthal PD	Ophthal RRC	Rotation schedule for 04/05
02/07/05	DIO	IRC Exec Dir	JCAHO withdrawal
02/25/05	ENT PD	ENT RRC	NO SUBJECT SPECIFIED
03/11/05	ADA	CEO	Acknowledged loss of JCAHO
03/21/05	Fam Med RRC	Fam Med PD	Site visit confirmation
03/22/05	DIO	IRC	New PD in Psychiatry

Affiliation Agreement Between
Los Angeles County King/Drew Medical Center and
C.R. Drew University - #75086
Contract Monitoring Summary Report

Contract Quarter: *3rd QTR (April 1 - June 30,2005)*

DATE: *August 16, 2005*

Summary Report of Non-compliance ☑ :

Section I. General Contract Provisions (Boilerplate)	Contract Section(s)	Description of non-compliant area(s)	Accountable Mgmt
☐ 2. Responsibilities of University			
☐ 3. Responsibilities of County			
☑ 4. Joint Responsibilities	*4.1.*	*Compliance & Cooperation, pg 2*	*R. Peeks/R. Lau*
☐ 5. Purchased Services			
☐ 6. Payment for Purchased Services			
☐ 8. Joint Planning & Ops Committees			
☑ 9. Reporting & Accountability	*9.3.1.*	*Financial Records, pg 2*	*R. Lau*

Section II. Addendum A Contracted Services:	Documented Hours	Verified Hours	Variance	Accountable Mgmt
☐ A.2.1. Clinical Services	N/A	*YES*	N/A	*R. Peeks/R. Lau*
☐ A.2.2. Academic Services	*YES*	*YES*	N/A	*R. Peeks/R. Lau*
☐ A.3. Purchased Clinical Services	N/A	*YES*	*NO*	*R. Peeks/R. Lau*
☐ A.4. Purchased Academic Services	N/A	*YES*	*NO*	*R. Peeks/R. Lau*

Percentage of non-compliance w/ documented hours: *0* %

Percentage of non-compliance w/ verified hours *0* %

Total hour variance Purchased Clinical Services: _____ Purchased Academic Services: _____

Section III. Addendum B Contracted Services:	Description of non-compliant area(s)	Sanction Amount	Sanction N/A	Accountable Mgmt
☐ B.2. Academic Performance				
☐ B.3. Patient Care Performance Improvements			N/A	
☐ B.3.4. Physician Staffing and Compensation				
☑ B.4. Communication and Information Sharing	*See description, pg 2*			*S. Ashley/M. Willock*

Sanction amount: $_____ Date Levied_____ Percentage of monthly contract amount: _____%

Description of compliance issues:

4.1. ***Compliance and Cooperation***

Contract states: The University shall develop and County and University shall jointly approve written criteria for the award of faculty stipends. The written criteria shall be developed by April 30, 2005 and fully implemented by University by June 30, 2005

- ***The University failed to develop written criteria for the award of faculty stipends.***

Description of compliance issues: ***page 2***

9.3.1. Financial Records

- ***The University failed to prepare/maintain accurate and complete financial/operational records as they apply to requirements set forth in Addendum A, Purchased Services. The University has been mandated to complete by May 20, 2005, a comprehensive analysis and reconciliation of all claimable hours***

B.4. Communication and Information Sharing

The Agreement states that the University shall provide all ACGME, RRC and IRC... correspondence to the Director of Health Services on the day such correspondence was received... Continued failure to provide informaion constitutes a recurring breach for this contract quarter.

- *The University failed to provide the following correspondence:*

DATE	FROM	TO	SUBJECT
04/20/05	Int Med PD	Int Med RRC	New Program Director Endocrinology
04/21/05	Int Med RRC	Endocrin PD	Welcomes New Endocrin PD
04/30/05	Int Med PD	In Med RRC	Progress Report required by RRC
06/09/05	Ortho PD	Ortho RRC	Program Updates
06/17/05	ENT PD	ENT RRC	Progress Report required by RRC
06/21/05	OB/GYN RRC	OB/GYN PD	Request for Approval of an Additional Rotation in the Senior Year

Overall quarter compliance percentage: *94* **%** *(N=97)*

ANNUAL REPORT
GRADUATE MEDICAL EDUCATION COMMITTEE

CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE

Reporting Period: July 1, 2004 to June 30, 2005

This Annual Report (the "Report") of the Graduate Medical Education Committee ("GMEC") of Charles R. Drew University of Medicine & Science (the "University") is being submitted to Thomas T. Yoshikawa, M.D., Provost-Chief Operating Officer/Acting President, Ronald A. Edelstein, Ed.D., Acting Medical School Dean, Thomas Garthwaite, MD, Chief Executive Officer/DHS Director, and the System JPO Committee. This Report is submitted in accordance with § 8.2.4.2.5 and Addendum B, § B.4, of the Affiliation Agreement with the University and the County of Los Angeles (the "County") dated October 1, 2004 (the "MSOA" or the "Agreement").

The Report summarizes the graduate medical education activities for the period of July 1, 2004 to June 30, 2005, and reviews the ability of each Training Program to meet the institutional and program accreditation standards of the Accreditation Council on Graduate Medical Education (ACGME). The Report will include the following for the Training Programs and facilities under the purview of the Graduate Medical Education Committee (GMEC), as required by MSOA § 8.2.4.2.5 (order of presentation in this report indicated by roman numerals): "[I.] an overview of the status of the Training Programs; [V.] overall graduate educational activities; [III.] common problems and concerns across the Training Programs; [II.] and each Training Program's compliance with ACGME institutional and program requirements; [IV.] University's role in overseeing these activities under the Agreement; [VI.] and an analysis of the academic accomplishments of the Faculty and other performance criteria in § 6. and any Addenda."

Finally, the Report will address the Goals of the GMEC for the 2005/2006 academic year in Part VII, below.

I. Overview of the Status of the Training Programs

A. GME and University Leadership

Effective July 1, 2005, Nancy F. Hanna, MD, replaced Sharon Ashley, MD, MPH, MBA, as Associate Dean for Graduate Medical Education and Designated Institutional Official. Dr. Hanna will report directly to Thomas Yoshikawa, MD, who was appointed Provost-Chief Operating Officer and Acting President of the University, effective July 1, 2005. Sandra Gonzalez, PhD, will continue as Director of Graduate and Undergraduate Medical Education. The GME Office is in the process of recruiting an Office Manager, which would be a new position in the office. Ronald A. Edelstein, EdD, replaced Medical

School Dean Marcelle Willock, MD, MBA, on an interim basis upon Dr. Willock's retirement on June 30, 2005.

In a December 2004 GMEC meeting, it was reported that the Drew University Board of Trustees elected four new members, thus broadening the governing body's diversity and expertise. The four new board members are Roger J. Bulger, MD, Alejandro Mayorkas, Esq., Steven A. Schroeder, MD, and Richard A. Veloz, MPH. Thomas M. Priselac, MPH, President and CEO of Cedars-Sinai Health System was subsequently appointed to the Drew University Board of Trustees in June 2005. Bart Williams, Esq., continues as Chairman of the Board.

All Program Directors without exception are Board Certified by their specialty and/or subspecialty American Boards. Program Directors with new appointments between July 1, 2004 and June 30, 2005 include the following: Roya Yumul, MD, Program Director, Anesthesiology; Don Sanders, MD, Program Director, Orthopedics; Stanley Hsia, MD, Program Director, Endocrinology; and Vijayalakshmi Ranganath, MD, Program Director, Psychiatry.

B. Accreditation Status of the Institution

In its July 8, 2004, notification letter, the Institutional Review Committee of the ACGME confirmed a continued unfavorable institutional status. The next institutional review, which had been scheduled for April of 2006, was accelerated to December of 2005 in an ACGME correspondence dated December 2, 2004.

The ACGME sustained two citations, which led to the Institution's unfavorable status. These citations relate to 1) oversight of the residencies, and 2) effectiveness of the internal review process.

The institutional accreditation status has been a major concern to the leadership of the University, the GMEC (comprised of all program directors and associate directors), and the GME Executive Committee, which is comprised of the DIO and the following designated members: Glenda Lindsey, MD, Program Director, Pediatrics; Malvin Anders, MD, Program Director, Ophthalmology; Richard Leathers, DDS, Program Director, Oral-Maxillofacial Surgery; Roya Yumul, MD, Program Director, Anesthesiology; Rosetta Hassan, MD, Program Director, Obstetrics & Gynecology; Muhammad Farooq, MD, Program Director, Family Medicine; and Roslyn Scott, MD, Department of Surgery. The GMEC has met monthly over the past academic year to provide oversight over all residency programs to ensure that education of the residents and quality of patient care are the priorities of all programs. The GMEC Executive Committee generally meets 30 minutes before the GMEC and addresses common program citations, concerns and potential problems, which they then present to the GMEC for discussion and approval.

Since receiving the unfavorable status decision from the ACGME, the Institution has committed substantial resources to GME in order to achieve compliance with the

ACGME's Institutional Requirements. The GME office has expanded and restructured its staff to better support and oversees the residency training programs. These expanded oversight activities include assistance with PIF preparation, direct participation in negotiations to remediate deficiencies, mock site visits and document review by outside expert reviewers. The GMEC, includes all the program directors, meets monthly, and performs all the duties and responsibilities as required by the ACGME. The functions, operations and effectiveness of the GME Office have significantly improved since 2001. During 2004, several of our programs received full accreditation: Psychiatry, Pediatrics, Obstetrics and Gynecology, Emergency Medicine, and Internal Medicine, which also included Endocrinology, Infectious Diseases, Geriatrics and Gastroenterology.

The GMEC has reviewed the internal review protocol over the previous academic year, adding the requirement that program directors complete the Program Information Form prior to the review meeting. The GMEC and the Internal Review Committee have been providing a detailed analysis and plan of correction for all reviewed programs. The GME Office is committed to scheduling all program internal reviews at the mid-point of the each program's review cycle, as required by ACGME.

The GMEC reports that there were increased publications and there are four academic journals based at Charles R. Drew University of Medicine and Science. Notably, the pass rates of first-time board takers have been steadily improving as a result of the program directors increasing their use of board review lectures and test questions, and recruiting and retaining better qualified residents.

In order to achieve excellence and move towards regaining a favorable accreditation status for the Institution, Dr. Sharon Ashley participated, and Drs. Hanna and Gonzalez will continue to participate, in the quarterly meetings of the Associate Deans for GME of the University of California Health System.

Additionally, the UC Advisory Committee was formed pursuant to Assembly Concurrent Resolution No. 139, as a "joint advisory team to develop recommendations to the leadership of the Martin Luther King, Jr. /Charles R. Drew Medical Center for training programs for residents at the Martin Luther King, Jr. /Charles R. Drew Medical Center in order to achieve or maintain, or both, accreditation by the Accreditation Council for Graduate Medical Education." The UC Advisory Committee, chaired by a representative of the Office of the President, University of California, is comprised of key leaders from Drew, including the DIO and the Medical School Dean, and various accreditation advisors from UCLA. The Committee generally meets twice per month and has been helpful in formulating plans of correction for the Family Medicine Program as well as strategizing regarding site visits and the upcoming institutional site visit in December.

In addition, the University's Board of Trustees retained Nixon Peabody LLP to assist with several processes necessary to institutional review preparation, including the review of program information forms (PIFs), the Institutional Review Document (IRD), and other GME-related issues. The County of Los Angeles has retained Mr. Alan J. Burgener, an experienced GME consultant recommended by ACGME, who consults to

DHS leadership, the DIO and the GME Director regarding institutional review preparation. Finally, the University has retained Kim Crooks, PhD, Director of Graduate Medical Education at UCLA, as a consultant to assess the Graduate Medical Education Office, interview the Graduate Medical Education staff, and help with preparation of an initial GME Office matrix. Her current consultative focus is the Institutional Review Document (IRD). Dr. Crooks is also a member of the UC Advisory Committee.

In March of 2005 the GME Office began hosting open forums with the residents and fellows to address any questions and concerns and to keep them informed on matters associated with the Institution. These open forums are led by the DIO and the GME Director. A list of all the upcoming Open Resident Forums was disseminated to program directors and coordinators and flyers are posted prior to each meeting.

The Dean for Faculty Development planned and scheduled the first faculty development session for a speakers from Vanderbilt University, who provided a matrix that can be used as a tool for root cause analysis, which in turn, can be used to promote program-level improvement in educational quality. Drew initiated in 2004 a Master of Science in Clinical Research degree program, a 2-year course for faculty on how to perform clinical research and publish scientific papers. Currently, 10 faculty are enrolled.

In compliance with the ACGME requirements, all current residents in and applicants to the ACGME-accredited programs were advised in writing of the ACGME Institutional Review Committee's accreditation action and all program directors were informed of the Sponsoring Institution's unfavorable status, and that they may not apply for accreditation of any new or previously withdrawn programs until the unfavorable status has been removed following a site visit of the Institution and review by the IRC.

Despite the University investing significant resources in improving the oversight and support of activities affecting GME, not the least of which is the July 1, 2005, installation of a new leadership team under the direction of Drs. Yoshikawa and Edelstein, the hospital's loss of JCAHO accreditation will potentially adversely impact accreditation of all residency training programs as well as the Institution. (Please refer to section IIIA under "JCAHO Accreditation).

II. Each Program's Compliance with ACGME Institutional and Program Requirements

There are 16 medical residency training programs sponsored by Charles R. Drew University of Medicine and Science and all are accredited by the ACGME. The Oral & Maxillo-facial Surgery (OMFS) and General Dentistry programs are fully accredited by the American Dental Association (ADA) and are sponsored by the County of Los Angeles. (See attachment #1)

The GMEC provides oversight for all 17 accredited programs and one ACGME/RRC withdrawn program. Of the 18 programs, 14 are fully accredited and 3 programs are on

probationary accreditation, and one has had its accreditation withdrawn. Anesthesiology and Family Medicine are continued on probationary accreditation; Orthopedics was placed on probationary accreditation effective January 14, 2005, after a proposed probationary status on March 22, 2004. After an appeal presented in November 2004, the Neonatal-Perinatal Medicine program was withdrawn by ACGME/RRC in a letter dated April 23, 2004, effective June 6, 2006; furthermore, the program did not accept a new fellow for July 2005.

The Internal Medicine Residency Program, which had previously received probationary accreditation, was awarded full accreditation with no citations in November of 2004. Furthermore, the program was awarded three commendations in the ACGME/RRC letter dated November 3, 2004. The program subsequently submitted a Continuity of Care status report, as required, to ACGME/RRC May 1, 2005. An unsolicited post site visit status report was provided to the Orthopaedics RRC in June of 2005 prior to the RRC meeting in June 2005.

Of the 14 fully accredited programs, seven programs were awarded continued full accreditation during the previous academic year: Endocrinology, Gastroenterology, Infectious Disease, Geriatric Medicine, Psychiatry, Obstetrics & Gynecology (a progress report due December 1, 2005), Otolaryngology (one progress report was approved and accepted by ACGME/RRC letter dated March 1, 2005; a second progress report response was sent to the ACGME/RRC June 16, 2005; and a third progress report is due December 15, 2005).

Four programs were not visited during the past academic year and retained their status of full accreditation: Emergency Medicine, Ophthalmology, Pediatrics, and Oral & Maxillo-Facial Surgery.

Three programs were site visited by ACGME/RRC and final reports are pending: Dermatology was site visited March 14, 2005, and holds continued full accreditation status; and Orthopedics was site visited March 7, 2005, and holds probationary accreditation status. The General Dentistry Program was surveyed by the American Dental Association on December 8, 2004 and is awaiting an accreditation notification.

Three programs should be site visited by ACGME/RRC between July 1, 2005, and June 30, 2006: Family Medicine is scheduled for August 30, 2005; Anesthesiology should be visited in January, 2006; and Emergency Medicine should be visited in February, 2006. Psychiatry is due for its site visit in April, 2006.

The loss of JCAHO accreditation by King/Drew Medical Center has challenged all training programs. The OMFS and Dentistry programs have been placed in jeopardy by the loss of JCAHO accreditation. These programs received communications in June, 2005, indicating that the ADA would consider withdrawing approval as a result of the loss of JCAHO accreditation. A progress report was sent to the ADA, and a response is pending.

Of the 17 programs, 3 (18%) were site-visited by the ACGME during the academic year. Additionally, 10 (59%) programs received notification letters from ACGME with accreditation status as follows:

Table 1. ACGME Notification Letters Between 6/29/04 and 6/30/05

PROGRAM	ACCREDITATION STATUS	DATE OF THE LETTER
Psychiatry	Continued Full Accreditation	06/29/04
Obstetrics & Gynecology	Continued Full Accreditation	06/30/04
Otolaryngology	Continued Full Accreditation	09/30/04
Internal Medicine	Full Accreditation	11/03/04
Endocrinology	Continued Full Accreditation	11/03/04
Gastroenterology	Continued Full Accreditation	11/03/04
Infectious Disease	Continued Full Accreditation	11/03/04
Geriatric Medicine	Continued Full Accreditation	11/03/04
General Dentistry	Approval from American Dental Association	12/08/04
Orthopedics	Probationary Accreditation	01/14/05

III. Common Problems and Concerns Across the Training Programs

A. JCAHO Accreditation

King-Drew Medical Center lost JCAHO accreditation effective February 1, 2005, and its continued loss threatens the accreditation of every program as well as the Institution's accreditation. For example, the Orthopaedics recent review indicated preliminarily that the Institution's JCAHO status greatly influenced the designated probationary status of the program; the lack of JCAHO accreditation prohibited pediatric patients belonging to the Community Health Plan (CHP) from utilizing King/Drew Medical Center and consequently greatly reduced the hospital census of children patients, which in turn will adversely impact on the pediatric residency program. Furthermore, the renovation of the operating rooms (a necessity for JCAHO re-accreditation) will also adversely impact training programs (see section IIIK).

Drew University responded to the ACGME's serious concerns about the loss of JCAHO accreditation with a detailed explanation of the potential for equivalency between JCAHO accreditation and Centers for Medicare/Medicaid Services certification which King/Drew still maintains. The IRC accepted this equivalency thereby removing all ACGME accredited programs from potential immediate jeopardy. The IRC accepted this equivalency with the expectation that JCAHO accreditation was being pursued. However, each RRC maintains a significant degree of accreditation independence and may independently take the lack of JCAHO accreditation into consideration when making accreditation decisions.

The Navigant consulting group, which has managed King-Drew Medical Center since November 2004 under a contract with the County, routinely assesses different measures of quality of care and patient safety, i.e., performance measures, mock surveys, patient safety rounds and case reviews, in order to prepare for future accreditation by JCAHO. Navigant plans to have multiple JCAHO Mock Reviews during the next six months. If compliance can be demonstrated with reasonable certainty, it is our understanding that the hospital administration would request a follow-up JCAHO site visit in an effort to restore King-Drew Medical Center's accreditation in or around December 2005, prior to its institutional site visit.

B. Permanent Chair Recruitment

Difficulty with recruitment and retention of permanent Chairs is a common problem in many of our Training Programs, especially Anesthesiology, Family Medicine, Pediatrics and Psychiatry. The lack of JCAHO accreditation, uncertainty of ACGME accreditation of the Institution, excessive scrutiny by the County of Drew physicians, perceived or real inadequate support for faculty and department activities, repeated negative reports in the local media, and non-competitive salaries are some of the major reasons for the difficulty in recruiting and retaining department Chairs. Acknowledging the urgent need for strong educational leadership, the University with the medical administration is working diligently on recruiting, interviewing, and selecting the chairs needed for the above-mentioned departments. In the very near future, the University expects to designate Chairs for two of the above-mentioned departments, i.e., Psychiatry and Family Medicine.

C. Faculty to Resident Ratio

After the loss of the Medical Center's JCAHO accreditation, and with the present ACGME unfavorable status of the sponsoring institution, the prospects for faculty recruitment are challenging (for similar reasons as mentioned above for recruitment of Chairs). This is a potential problem in particular for the programs in Emergency Medicine, Dermatology, Otolaryngology and Psychiatry.

Acknowledging the urgency of the Training Program needs, the University with the Chairs, GMEC, and medical administration, has been working diligently on implementing creative methods of faculty recruitment. At GMEC meetings, the faculty recruitment methods discussed have included, but have not been limited to, the suggestion of alleviating the problem by allowing contracts for H1 and J1 visa holders. The question was raised as to whether the County will accept J1 visas if the University was the sponsor. The GMEC also discussed and recommended that all programs continue to invest and groom their own resident graduates for future junior faculty roles. Data indicate that over 50% of Drew faculty have had their previous training in Drew-sponsored residency or subspecialty fellowship programs.

The GMEC had discussed and approved the Program Directors Educational Forum, which began April 11, 2005. The Forum is conducted monthly and composed of Program Directors from each University Residency Training Program. Topics recommended for the forum have included: resident morale, faculty development, health care disparities, developing a resident research curriculum, program directors as managers and leaders, getting what the program needs from the participating institution, conflict management and crisis intervention, academic appointments, and developing useful resident evaluations.

D. Resident Recruitment and Retention

After the Medical Center's loss of JCAHO accreditation and with the present ACGME unfavorable status of the sponsoring Institution, resident retention and recruitment has been problematic. The programs with particular difficulties in resident recruitment and retention include Anesthesiology, Emergency Medicine, Internal Medicine, and Psychiatry. Some program directors with the assistance of the GMEC started a plan of correction including but not limited to filling some of the open first-year positions outside the match and searching through the international candidates for the best candidates. The GMEC convened a task force to develop and implement a new recruitment and selection policy, which was approved by the GMEC during the previous academic year.

E. Patient Census

The loss of JCAHO and therefore CHP patients (as noted in section IIIA) has significantly decreased the number of patients and thus reduced the number and variety of procedures available to residents in training, particularly in the following programs: Pediatrics, Family Medicine, and Otolaryngology. The opening of the new King-Drew Women's Center on June 27, 2005, and the expansion of the Pediatric Emergency Room to run for 24 hours/day as of September 6, 2005, are expected to improve the outpatient numbers. The GMEC and the Program Directors have been exploring the possibility of additional outside rotations to increase the experience of the residents. Some of the programs have the ability to make this adaptation until JCAHO accreditation of the hospital is reestablished. The program directors are closely monitoring the daily census in both inpatient and ambulatory services and regularly reporting to the GMEC.

F. Patient Mix

The lack of appropriate patient mix as required by ACGME and individual RRCs is a common concern, in particular for the following programs: Ophthalmology, Family Medicine, Dermatology, Pediatrics, and Otolaryngology. The GMEC and the Program Directors have been exploring the possibility of additional outside rotations to increase the experience of the residents.

G. Scholarly Activity

Insufficient scholarly activity has been a concern and a potential problem for some programs including Orthopedics, Otolaryngology, and Psychiatry. The GMEC and the University formed an institutional curriculum committee to start a common curriculum addressing the core required conferences including basic research education. Additionally, recruitment of new faculty with research interests, as well as faculty training in research (see section IB re: Master of Science in Clinical Research degree program) will help correct this deficiency.

At the July 2004 GMEC meeting, the need for research mentors for the residents was discussed, in part because the quality of proposals being submitted by residents has not been up to the University standards. It was recommended that an internal research committee be formed to closely monitor and address the problem.

At the November 2004 GMEC meeting, it was recommended that all faculty attend the sponsored seminars for Faculty Development. There were also additional seminars being offered for senior residents. At the March 2005 GMEC meeting, Dr. Kathy Russell encouraged the program directors to take advantage of the services provided by the Learning Resource Center (LRC) to support their program's scholarly activates.

H. Core Curriculum

The lack of an organized curriculum and evidence of integration of the six ACGME Competencies had been concerns for Ophthalmology, Orthopedics, and Psychiatry. In correct this potential problem; the program directors have revised their current curricula. The GMEC and the University formed an institutional curriculum committee to address the common core required conferences including basic research education.

I. Board Pass Rate

Board passage rates have been a concern for the following programs: Anesthesiology, Pediatrics, and Psychiatry, all of which have shown a great consistent improvement in comparison with previous years.

The program directors recommended and the GMEC approved the following changes;
1- Implementation of a board review course for senior residents and referral of residents to educational specialists to assist with test-taking skills.
2- Individualized remediation plans for residents with poor exam performance.
3- Analysis of the residents' performance on both in-service and certification exams to clarify underlying reasons for deficiencies and to develop appropriate interventions.
4- Implement weekly or monthly didactic conference using the oral board format at which senior residents present cases to practice oral presentation.
5- Study feasibility of bringing graduates back for oral board review course one year after graduation

J. Clinical Space

The availability of space sufficient as per ACGME/RRC requirements is a concern for the following programs: Emergency Medicine, Family Medicine, Ophthalmology, and Psychiatry. The GMEC has analyzed every program space problem and presented requests for remediation to the Medical Administration representative during the GMEC and the JPOC meetings.

K. Operating Room Renovation Plans

Part of the process and plans for the Medical Center to regain JCAHO accreditation was the need for major Operating Room renovation. The anticipated time for the required renovations is six to seven months. This problem will affect many programs due to relocation, reduced numbers of operative cases and other related issues. The following programs will be most substantially affected: Anesthesiology, Orthopedics, Otolaryngology, Ophthalmology, and Obstetrics & Gynecology. The anticipated reduction in operating room availability will make it difficult for the above mentioned programs to meet ACGME/RRC resident experience requirements. Some outside rotations have been or are being arranged by the program directors (and were approved by the GMEC) to cover required needs during the period of renovation.

L. Loss of Surgery Program

The ACGME/RRC withdrawal of accreditation from the Surgery Residency Program is a concern, especially for the following programs: Anesthesiology, Emergency Medicine, Orthopedics, Otolaryngology, Ophthalmology, and Family Medicine. The ACGME and RRCs do not require the presence of a Surgery Residency Program for the accreditation of some of these programs. The use of outside rotations to meet training requirements was approved by the ACGME/RRC for one program and others are in the process of being arranged. However, in some specialties, e.g., Anesthesiology and Orthopedics, there is a requirement that the Sponsoring Institution also offer a General Surgery Residency Program or affiliation. There is an institutional plan to reestablish a General Surgery Residency Program depending on the outcomes of the JCAHO and ACGME site visits.

M. Lack of Radiology Services

Radiology films are now available through the Picture Archiving and Communication System (PACS). Workstations had been strategically placed in additional locations during the previous academic year to expand access for the inpatient and outpatient services. The main continuing concern is the loss of multiple faculty members in the Radiology Department, which is slowing the provision of clinical services with a substantial backlog of unread films and images. This problem AFFECTS ALL PROGRAMS, WITH PARTICULAR PROBLEMS FOR Emergency Medicine and

Internal Medicine, which see the vast majority of patients arriving at the hospital. Moreover, Emergency Medicine and Otolaryngology were previously cited by their respective RRCs for lack of radiology service support. Medical Administration is aware of the problem.

N. Medical Records

King-Drew Medical Center has been monitoring the medical records retrieval for the inpatient and outpatient services and has shown an improvement, with nearly 90% of all requested medical records available to the inpatient and outpatient services. However, the medical records at the Hubert Humphrey Clinic (HHC) have fallen far short of this level of performance. According to the GME Office analysis reported to the GMEC, medical records at the Family Medicine Center at HHC were available, on average, for only 47% (range: 22% to 65%) of the total patient visits (the 47% reflects presence of any information for each chart and not necessarily complete data for each patient). This value falls to 10% if the analysis includes availability of all old and new information for each chart. In addition, progress notes that are generated in the absence of the chart were never filed in the chart making most medical records incomplete. Such consistent lack of patient charts will invariably lead to a citation for the Family Medicine program. This issue has been raised in meeting with the HHC administration. The correction of this problem is in progress with the assistance of the Medical Center administration. In addition to the threatening Family Medicine's accreditation, this problem also created a concern for the Geriatric program.

O. Resident Supervision and Duty Hours

Patient volume on the Psychiatric Emergency Service routinely exceeds the facility's maximum allowed patient volume (19 maximum). This is a systemic problem in which the County-wide diversion plan either fails or is inadequate to accommodate the emergency needs of the County's psychiatric patients. The service burden to both faculty and residents threatens the provision of adequate supervision. This was addressed with the County Department of Health Services to ensure patient safety and to ensure compliance with resident supervision policies. The GMEC recommended convening a task force of department leadership, psychiatry residents, hospital administrators and Department of Mental Health Service (DMHS) leadership to identify systemic causes of this problem and to articulate a remediation plan. The ability of the program to remediate this problem depends on the cooperation/collaboration of the DMHS, DHS and hospital administration. Another example of duty hour violations included Orthopaedics residents when physician assistants were not available and the residents assumed a greater burden of clinical duties. This has been corrected.

P. Resident Evaluation

The GMEC noted that with some programs, provisions were not being made for residents to confidentially evaluate the program. This problem has been resolved with the

implementation of Verinform, which provides confidential on-line evaluation tools for use by all residency programs.

Q. Administrative Staff

The Dermatology and Psychiatry programs reported to the GMEC and to the Internal Review Committee their need for a program coordinator. The DIO circulated a copy of the program coordinators job description for review by the GMEC. The Joint Planning and Operations Committee asked the GMEC to submit a job description for the program coordinators to allow for consistency and continuity of duties and responsibilities throughout the residency programs.

At the September 2004 GMEC meeting, the creation of a subcommittee was proposed to look into the implementation of program coordinator job description. This activity is still underway.

IV. University's Role in Overseeing These Activities Under the Agreement

The University is the sponsor for the residency programs. As the sponsor and as an institution of higher learning, Drew is responsible for ensuring an appropriate curriculum, quality of training, appropriate supervision of trainees, proper qualifications of faculty, adequate support structure (e.g., administration) and the meeting of all requirements of the RRCs and ACGME for the residency training programs. However, since training occurs in a non-Drew facility, i.e., a County-owned and -operated hospital, the administrative and operational elements of a hospital that are necessary for residency training are a responsibility of the County (i.e., physical structure, nursing, pharmacy, patient volume, support staff, equipment, supplies, etc.). Thus, under the Agreement, a dual responsibility for overseeing the training activities is ultimately in place, and appropriately so.

V. Overall Graduate Educational Activities

A. Summary of Internal Review Committee Reports

The GMEC conducted seven Internal Reviews during the academic year 2004-2005: Dermatology, Family Medicine, Orthopedic Surgery, Psychiatry, Infectious Disease, Emergency Medicine and Ophthalmology. The GMEC approved, August 30, 2004, a change to the Internal Review policy, to make the completion of the Program Information Form a mandatory part of the Internal Review process. The revisions to the Internal Review policy were unanimously accepted by the GMEC. Each Internal Review Committee (IRC) was chaired by a program director or associate program director from a program other than the one under review. The GME Office also selected two to three faculty members and a resident for each Internal Review Committee. The DIO and a hospital admistrator participated in all internal reviews. The IRC protocol required interviews with the program director; faculty; and peer-selected residents in two separate sessions of 90 to 120 minutes each, depending on the size of the program and the number

of citations and concerns. The Internal Review chair or the DIO submitted a written report to the GMEC. The GMEC reviewed and discussed the report, modified it as needed and approved it with recommendations regarding corrective actions. The approved report was delivered to the program director with the expectation that a corrective action plan be submitted for each concern within two to three months. The corrective action plan was subsequently presented to the GMEC, reviewed, and approved as submitted or returned to the program director for additional corrective action. The approved Internal Review report and the approved corrective action plan were forwarded to the Dean and King-Drew Medical Center administration according to the MSOA.

In addition to overseeing the internal review process, the GMEC also conducted a mock site visits Internal Medicine, Orthopaedic Surgery, Dermatology and General Dentistry. This assisted the programs' leaders in preparing for the ACGME/RRC site visit and contributed to the attainment of full accreditation in this specialty.

B. Institutional Policies

The GMEC has developed policies and procedures to meet the ACGME Institutional requirements and fulfill the expectations of DHS. The GMEC requires that each program develop policies and procedures for all of the applicable institutional and program requirements set forth by ACGME/RRCs. The GMEC reviews the institutional policies every two years. During 2004-2005, the GMEC reviewed the Matriculation and Grievance Policy and modified it to include a full disclosure clause. Copies of the new Impaired Physician Policy were distributed for each committee member; one program director volunteers to sit on the Physician Well-Being Committee in order for the GMEC to understand and better utilize its services. The GMEC also revised the Resident Selection and Promotion Policy.

C. Compliance with Duty Hours and Resident Supervision

MSOA, B.3.1 (1)
The GMEC was assured that each program director has established roles and responsibilities for each resident according to their level of training and has developed duty hours and resident supervision policies or adopted the GME institutional policy. The GME office conducted an anonymous survey in April, 2004 to evaluate resident perceptions of duty hours and supervision, as well as to show evidence of faculty supervision in compliance with ACGME and the County of Los Angeles Policies and Procedures. Some of the examples included in survey (N=82) are 68% of residents surveyed indicated that to a moderate to great extent, the programs provide adequate and prompt supervision of residents and 57% of residents indicated that to a moderate to great extent the programs correct situations that cause stress among them. The GMEC continues to monitor closely supervision requirements for all programs. A new process for addressing resident stress has been established.

The duty hour and supervision policies are to be enforced at the sponsoring institution and all of its affiliates. The institutional policy meets all of the ACGME duty hour

requirements and incorporates the requirements of DHS. The GMEC also has made available the sleep, alertness and fatigue lecture which is repeated through the year. A copy was given to all programs and is also available in the GME Office for resident and the faculty education.
The duty hour compliance "hot line" was monitored daily (310) 668-8168. Use ranged from 0 - 1 call per month. All calls are investigated within 24 hours. Most of the calls were confirmed to be sporadic events. Corrective action plans were developed and implemented for the areas of noncompliance. The GMEC will start to conduct anonymous duty hour monitoring and confidential surveys quarterly. The surveys will be analyzed by the DIO and results will be reviewed by the GMEC and distributed to individual program directors.

At the January 2005 GMEC meeting, the duty hour problems were discussed and program directors were requested to report on any possible duty hour violations caused by residents rotating in other departments. It was communicated to the other program directors to that they must assure that residents have time-off as required per policy (one day off for every seven days worked). Review of this issue at subsequent GMEC meetings revealed that the problem had been corrected.

In addition to the GMEC oversight, the Navigant Quality Improvement Committee audits resident supervision through periodic chart reviews. Results of these audits are provided to the chief medical officer and the DIO during the JCIR monthly meeting. Additional audits are conducted through departmental improvement of performance committees.

MSOA,B2.2 (4) requires, "No less than annual completed performance evaluations of faculty by housestaff, and level of supervision provided, in accordance to ACGME guideline." (See Attachments #2)

D. Resident Responsibilities

The GMEC uses the internal review process to ensure residents develop a personal program of learning to foster continued professional growth under the guidance of the faculty. The internal review also assesses schedules and attendance records. Resident interviews are conducted to ensure that residents fully participate in the educational and scholarly activities of the program.

As stated earlier, the GMEC conducted an anonymous, confidential resident survey in April, 2004, to assess the faculty and the curriculum as part of the internal review process. Each program is reviewed to ensure that residents have the opportunity to evaluate faculty and program curriculum at least annually, and the Joint Council of Interns and Residents (JCIR) meets with the DIO and medical director monthly to discuss issues related to patient care and resident education.

The Institutional GMEC has two or three peer-selected residents including JCIR representative, among its members to participate in the GMEC monthly meetings and

assure that the resident representative is included in all GME policy discussions. The policy related to physician impairment and substance abuse is provided to the residents at orientation with a handbook of institutional policies and procedures. Any major changes are distributed to residents by the Institution. The resident impairment policy is currently under revision by the GMEC.

E. Resident Evaluation

Resident evaluation by program directors and faculty is monitored by the GMEC through a yearly anonymous, confidential survey of all programs. Additionally, resident evaluation is a major focus of the internal review process. Results are made available to the GMEC and given to program directors for corrective actions. Additionally, each program director is charged with ensuring that residents are given the opportunity by the program director to provide anonymous, confidential evaluations of the program and faculty. Program directors and associate program directors are required to meet individually with each resident at least twice a year and provide residents with a summary of their evaluation. Program directors are also required to verify in writing that upon completion of the residency program, the graduating resident has demonstrated sufficient ability in all six ACGME General Competencies.

Program directors are monitored by the GMEC for compliance with the ACGME requirements. Each director has submitted a list of tools the program uses to measure the six competencies during their internal review.

The GME office conducted an anonymous survey in April, 2004 to evaluate resident perceptions of performance evaluation, as well as to show evidence of program responding effectively to residents concerns. Some of the examples included in the survey are 50% of residents indicated that to a moderate to great extent their performance evaluation has been helpful, 94% of residents indicated that they were given a written evaluation of their performance at least once per year, and 61% of residents indicated that to a moderate to great extent their program has responded effectively to residents complaints.

To facilitate consistent and anonymous evaluation processes across all programs, the on-lineVerinform software program was rolled out, March 1, 2005.

F. Resident Match and Complement

Charles R. Drew University of Medicine and Science programs at King-Drew Medical Center had 13 programs participate in the NRMP main residency match for 2005. Of the 55 position submitted, 38 were filled through the match and the rest were filled outside the match after the final matching results. The total resident complement for the academic year 2005-2006 is 243 to 244.

G. Resident Selection (MSOA § 2.5.1.2(1))

The University evaluates academic qualifications of candidates for County housestaff positions utilizing the resident selection policy which was revised during the academic year 2004-2005. At the GMEC meeting in August 2004, the DHS Finance Department gave a presentation on the documentation requirements for interns and residents. The goal of the presentation was to inform the KDMC program directors and program coordinators about the documents Medicare and Medi-Cal requires for interns and residents and that DHS Finance will coordinate all audits through the Graduate Medical Education Department. It was also reported to the GMEC that failure to provide the auditors with this documentation results in a loss of funds for the hospital and the residency programs. The GMEC voted and approved the new guidelines of the new resident selection criteria submitted to the committee at the 1/31/05 GMEC meeting. **MSOA** 2.5.1.2 (2) states that the University develops a list of qualified candidates for County housestaff in accordance with ACGME requirements and other academic and accreditation standards (See attachment #3 & 4)

H. Academic Discipline of Housestaff

MSOA; 2.5.1.5 (2) indicates that the University provides a process for academic discipline of housestaff following the revised matriculation policy.
The Resident Grievance, Matriculation Review Policy was revised, approved by the GMEC and was effective June 27, 2005. The resident failure to properly disclose material information during the application process for residency training or at any time thereafter became on of the reasons for termination of the residency program, III.E.1.e (See Attachment #5)

I. Rotators Orientation

MSOA; 2.5.1.7 (1) states that, "The GMEC is responsible for educating Housestaff rotating through the primary care facility from outside affiliate institutions."
All program directors have an orientation process in place which include but not limited to a detailed orientation package which cover the department policies and procedures, the rotation goals and objectives, and didactic and teaching activities. Some program directors will meet with the rotators at the start of the rotation.

VI. Analysis of the Academic Accomplishments of the Faculty

A. Faculty Accomplishments

MSOA, B2.2 (5) requires, "Academic accomplishments/merits of faculty, such as publications, teaching awards and membership in scholarly activities."

During the period of the previous academic year, July 1, 2004 to June 30, 2005, the academic accomplishment/merits of faculty included the following publications: 95 research articles, 27 book chapters and review articles, 12 case reports, and 72 abstracts and editorial letters. Currently, we have total of 83 papers in press. The University was awarded several research grants throughout the previous academic year (See attachment#6 &7)

All program directors are members of their specialty and subspecialty national societies. (See attachments#8)

Some faculty received awards over the previous academic year. (See attachment# 9)

B. Other Performance Criteria Identified in §6 and Any Addenda

MSOA, B.3.1 (2) we are aware of a patient satisfaction survey performed by the hospital in 2004. Physician attendance records have not been analyzed and it is not clear how this would be accessed or evaluated. We assume attendance refers to presence at work.

MSOA, B.3.1 (3) Physician documentation of clinical is being revamped with new forms being developed to ensure consistency of reporting and supervision of residents. Documentation of procedures data are currently only analyzed by program directors since we do not have an automated data retrieval system to get this information.

MSOA, B.3.1 (4) This report has been submitted monthly by the Chief Financial Officer of Drew in collaboration with the CFO of KDMC.
In the first quarter of 2005 King Drew Medical Center has made remarkable strides in their compliance with utilizing the CRM Inpatient Clinical Pathways for treating patients in the domains of medicine, surgery and obstetrics. Currently the full complement of the 16 developed clinical pathways have been fully implemented. With support from the Navigant Consulting group, close monitoring has been conducted on patients admitted with congestive heart failure (CHF) and community acquired pneumonia (CAP). According to the data we have collected, KDMC's placement rate of 58.7% of patients with CHF, one of the highest among the Department of Health Services' hospitals. As regards to patients assessed as having community acquired pneumonia our pathway placement rate of 42.1 % second to the highest county hospital institution.

VII. Goals of the GMEC for the 2005/2006 Academic Year

The GMEC has identified the following goals for 2005-2006:

1. 100% compliance with ACGME and institutional policies.

2. Correct the ACGME institutional status. (Attachment#10)

3. Reestablish the General Surgery Residency Program if and when JCAHO and ACGME accreditation are successful.

4. Revision of the GME policies and procedures annually instead of every two Years.

5. Conduct the resident survey quarterly in an effort to collect data and Implement changes in a timely manner.

CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE
RESIDENCY PROGRAM
STATUS OF RESIDENCY PROGRAMS AND GRADUATE MEDICAL EDUCATION

PROGRAMS AND SUBSPECIALTIES	DEPARTMENT CHAIRS	PROGRAM DIRECTORS	DATE OF LAST RRC SITE VISIT	DATE OF LATEST ACCRED LETTER	ACCREDITATION STATUS	INTERNAL REVIEW DATE	APPROX. DATE OF NEXT RRC SITE VISIT
Anesthesiology	Kenneth Lewis, MD, Interim	Roya Yumul, MD	5/10/02	2/11/04	Probationary Accreditation	5/28/04	1/2006
Dermatology	Vidya Kaushik, MD, Interim (7/01/05)	A. Paul Kelly, MD	3/16/05	3/4/03	Continued Full Accreditation Pending ACGME Results	Pending	PendingACGME Results
Emergency Medicine	Eugene Hardin, MD	Eugene Hardin, MD	11/18/03	5/25/04	Continued Full Accreditation	4/28/05	2/2006
Family Medicine	Lutful Akhanjee, MD,Interim	Muhammad Farooq, MD	1/15/03	2/25/04	Probationary Accreditation	11/17/04	8/30/2005
Internal Medicine	Vidya Kaushik, MD, Interim (7/01/05)	Cesar Aranguri, MD	8/3/04	11/3/04	Full Accreditation	11/2005	11/2006
Endocrinology	Vidya Kaushik, MD, Interim (7/01/05)	Stanley Hsia, MD	4/9/04	11/3/04	Continued Full Accreditation	11/2005	11/2006
Gastroenterology	Vidya Kaushik, MD, Interim (7/01/05)	Ioannis Giannikopolus, MD	4/7/04	11/3/04	Continued Full Accreditation	11/2005	11/2006
Infectious Disease	Vidya Kaushik, MD, Interim (7/01/05)	Vinod Dhawan, MD	4/8/04	11/3/04	Continued Full Accreditation	6/2005	1/2006
Geriatric Medicine	Vidya Kaushik, MD, Interim (7/01/05)	Arnel Joaquin, MD	4/8/04	11/3/04	Continued Full Accreditation	11/2005	11/2006
Obstetrics & Gynecology	Teiichiro Fukushima, MD	Rosetta Hassan, MD	2/3/04	6/30/04	Continued Full Accreditation**	1/2006	7/2007
Ophthalmology	Richard Casey, MD	Malvin Anders, MD	11/11/02	7/1/03	Continued Full Accreditation	6/2005	5/2007
Oral & Maxillo-Facial Surgery	Joseph McQuirter, DDS	Richard Leathers, DDS	4/22/03	8/15/03	Approval from American Dental Association	6/2006	2008
General Dentistry	Joseph McQuirter, DDS	Lynnette Jackson, DDS	12/8/04	Pending	Approval from American Dental Association	Pending	Pending ADA Results
Orthopedics	Don Sanders, MD	Don Sanders, MD	3/8/05	2/22/05	Probationary Accreditation Pending ACGME Results	12/17/04	Pending ACGME Results
Otolaryngology	Gus Gill, MD	Jimmy Brown, MD	2/10/04	9/30/04	Continued Full Accreditation**	8/2005	8/2006
Pediatrics	Richard Findlay, MD,Interi	Glenda Lindsey, MD	11/19/03	4/15/04	Continued Full Accreditation**	Pending	Pending Progress Report 4/2006
Neonatal-Perinatal Med.	Richard Findlay, MD	Richard Findlay, MD	1/16/03	2/16/05	Accreditation Withdrawal Effective 6/30/06	N/A	N/A
Psychiatry	George Mallory, MD, Interim	Vijayalakshim Rangantha, MD	2/18/04	6/22/04	Continued Full Accreditation	5/27/05	4/2006
Graduate Medical Education	Nancy Hanna, MD, Associate Dean, DIO	Sandra Gonzalez, PhD	9/9/03	5/12/04	Continued Unfavorable	N/A	12/2005

**Progress Report due to ACGME:
Obstetrics & Gynecology - December 1, 2005
Otolaryngology- December 15, 2005
Pediatrics - April 2006
Revised: 7/29/05

CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE
KING/DREW MEDICAL CENTER
GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES MANUAL

Division:	Graduate Medical Education	**Number:**	GMEC 03.005
Subject:	Resident Duty Hours and Working Environment	**Number of Pages:**	1 of 5
Approved by:	Graduate Medical Education Committee	**Effective Date:**	March 10, 2003
To be Performed by	The GMEC, all Program Directors and Faculty	**Revision Date:**	August 11 2003

Title: **Resident Duty Hours And Working Conditions**

Policy: The Graduate Medical Education Committee (GMEC) will ensure that each program establishes formal policies governing resident duty hours and on-call schedules that are not excessive, that foster resident education and facilitate the care of patients and provide safe working environment. Duty hours and working environment must be consistent with the Institutional and Program Requirements that apply to each program.

The institution will provide services and develop systems to minimize the work of residents that is extraneous to their educational program

The GMEC Committee will inform the program directors in a timely manner and ensure that all program directors are aware of and are complying with this policy.

Purpose: To establish policy guidelines for the purpose of:

1. Ensuring each program establishes formal policies governing resident duty hours and working conditions that are not excessive, that foster resident education, and recognize that faculty and residents collectively have the responsibility for the safety and welfare of patients.
2. Provide safe working environment.
3. Ensure that qualified faculty supervises all patient care.
4. Duty hours and working environment are consistent with the Institutional and Program Requirements that apply to each program.
5. The institution provides services and develops systems to minimize the work of residents that is extraneous to their educational program.

Scope: The Graduate Medical Education Committee establishes the requirements regarding duty hours and work environment for all GME Programs. Program Directors are responsible for following these guidelines, as well as, all program requirements and institutional requirements, when developing and implementing their program specific policies and procedures.

Procedure: **Supervision of Residents:** Each program will develop written policies that

ensure: 1.) Program Directors will direct and document adequate supervision of residents at all times; 2.)Residents are provided with rapid, reliable systems for communicating with supervising faculty, 3.) Faculty schedules are structured to provide residents with continuous supervision and consultation; and 4.)Faculty and residents are educated to recognize the signs of fatigue and in taking steps to prevent and counteract negative effects.

Duty Hours, Call Schedules and Days Off: Each program shall establish written formal policies governing resident duty hours and on-call schedules that are in compliance with program and institutional requirements. Duty hours must reflect the fact that responsibilities for continuing patient are not automatically discharged at specific times. Unless granted an exception because of very light night call responsibility or because of extended time-off following call, the institutional policy limits call to no more frequent that one night in three. Every program will provide one day in seven, when averaged over a 4-week period, free of all educational and clinical duties. Duty hours are limited to 80 hours per week, averaged over a four week period inclusive of all in house activity. Adequate time for rest and personal activities is provided, consisting of a ten hour time period provided between all daily duty periods and after in-house call.

The program policy ensures that residents are provided with appropriate backup support when patient care responsibilities are especially difficult or prolonged.

Program policies on duty hours, call schedules, and backup support must be included in the program's Policies and Procedures Manual.

Working Environment: The institutions will provide:

1. Adequate and appropriate food services and sleeping quarters.
2. Patient support services, such as intravenous services, phlebotomy services, laboratory services and messenger and transporter services.
3. An effective laboratory, medical records, and radiology information retrieval system that is essential to the appropriate conduct of the educational programs and quality and timely patient care.
4. Appropriate security and personal safety measures for residents in all locations including but not limited to parking facilities, on-call quarters, hospital and institutional grounds and related clinical facilities.

GMEC shall monitor the working environment through periodic written surveys of the residents.

On Call Activities(duty hours beyond normal work days when residents are required to be immediately available in the assigned institution)
In-house calls: a.) occur no more frequently than every third night averaged over a four-week period; b.) on-site-duty does not exceed 24 hours of continuous duty, (residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, maintain

continuity of medical and surgical care as defined by the Program); and c.) No new patients may be seen after 24 hours of continuous duty.

At home call/pager call (call taken from outside the assigned institution)

- Residents will be provided with one (1) day in seven (7) completely free from all educational and clinical responsibilities over a 4-week period;
- When residents are called into the institution from home the hours the resident spends in-house are counted toward the 80-hour limit; and
- Demands of at-home call will be monitored by program directors and faculty in their programs and schedule adjustments will be made to mitigate excessive service demands.

Moonlighting

- Internal moonlighting will be counted toward the 80-hour weekly limit on duty hours
- All program policies will comply with the institutional policies regarding moonlighting
- Program Directors will monitor moonlighting to ensure that it does not interfere with the ability of the resident to achieve goals and objectives of the educational program.
- Residents are required to get from their Program Director prospective written statements of permission to moonlight both internally and externally. (See Attachment A: Moonlighting Request Form)

Oversight

- All programs will be monitored on an ongoing basis by the Program Directors and the GMEC through Internal Review, oral and written resident surveys and spot checks for compliance to these policies
- All programs have policies and procedures consistent with the institutional and program requirements for residents on duty hours and working environments that are consistent with the GMEC Policies and Procedures
- Each Program will develop a back-up system for patient care responsibilities that are prolonged or unusually difficult, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

Duty Hours Exception: A Residency Review Committee of ACGME (RRC) may grant exceptions for up to 10% of the 80 hour limit, to individual programs based on a sound educational rationale. However, approval from GMEC for the proposed exception is required prior to submitting a request to the appropriate RRC.

Approval Process for Duty Hour Increase Requests

ACGME eligibility criteria require that the sponsoring institution have a favorable status from its most recent review by ACGME Institutional Review Committee. The requesting program must be in good standing, i.e., without a warning or a

proposed or confirmed adverse action.

Procedures And Criteria For The Institution Endorsing Requests For An Exception To The Duty Hour Limits: Programs seeking an exception to the 80-hour limit must submit a formal request to the Office of Graduate Medical Education. The request must address the following:

- **Patient Safety**: Information must be submitted that describes how the program will monitor, evaluate and ensure patient safety with extended resident work hours.

- **Moonlighting**: Specific information regarding the programs moonlighting policies for the periods in question must be included.

- **Educational Rationale**: The request must be based on a sound educational rationale which should be described in relation to the programs stated goals and objectives for the particular assignments, rotations and level(s) of training for which the increase is requested. Blanket exceptions for the entire program should be considered the exception, not the rule.

- **Call Schedules**: Specific information regarding the resident call schedules during the times specified for the exception must be provided.

- **Faculty Monitoring**: Evidence of faculty development activities regarding the effects of resident fatigue and sleep deprivation must be appended.

The Associate Dean for GME will oversee an initial assessment of the request for the exception and submit a report for review by GMEC. A majority vote by GMEC members present at the time, at which the proposal is considered, shall be deemed as institutional approval of the request for exception.

For programs requiring subsequent formal approval from RRC, the program making the request shall draft a letter to the appropriate RRC seeking approval for the exception. The Associate Dean for GME, as DIO, must co-sign the letter of request prior to forwarding the request for exception to RRC. Programs must forward a copy of the institutional policy on endorsing requests for an exception in duty hours limits must be attached.

Oversight

GMEC will continually monitor compliance with these policies through spot checks of call schedules, the resident hotline, and resident surveys. Program Directors should monitor time cards, call schedules, and resident evaluations and/or surveys. Program directors will be requested to submit evidence of meeting

these requirements at least annually to the GMEC.

Dissemination

Every effort will be made to institutionalize these policies. The Medical Director of the King/Drew Medical Center will be requested to distribute these Policies to all attending staff and nursing staff in order to assure compliance. Etc.

CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE
KING/DREW MEDICAL CENTER
GRADUATE MEDICAL EDUCATION POLICY AND PROCEDURE MANUAL

Division:	Graduate Medical Education	**Number:**	GMEC 03. 003
Subject:	Resident Application, Eligibility, Selection and Promotion	**Number of Pages:**	Page 1 of 4
Approved by:	Graduate Medical Education Committee	**Effective Date:**	August 11, 2003
To Be Performed By	All Program Directors and Office of GME	**Revision Date:**	August 11, 2003

Title: Resident Application, Eligibility, Selection and Promotion Requirements

Policy: The GMEC establishes the minimum Institutional and program requirements with regard to the Resident's application and acceptance process. Each residency program is responsible for the recruitment of candidates that are eligible for appointment as resident physicians. Each program must have written formal procedures for the application, evaluation, and selection of eligible candidates that meet the minimum GMEC requirements and the individual specific program requirements. Vacancies that occur out of phase with the matching programs or vacancies through unmatched positions will be filled only with applicants that meet the eligibility requirements noted above.

Purpose: To provide consistent institutional standards for the application process for residents applying for appointment to a program including application, eligibility, selection, and promotion.

Scope: The requirements apply to all Graduate Medical Education Programs.

Procedure: Program Director will assure GMEC that applicants (persons invited to come for an interview for a GME program) shall be provided with information in writing of the terms and conditions of employment and benefits including financial support, vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the resident and their family, and the conditions under which living quarters, meals and laundry or their equivalents are to be provided.

Each program director establishes the application, selection, and appointment process based on the minimum requirements established by the ACGME/RRC and its program requirements. Copies of the procedures will be submitted to the GMEC for annual review and approval at the beginning of the academic year.

The minimal requirements for eligibility and selection are:

- Applicants with one of the following qualifications are eligible for appointment to the residency programs:
  - Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
  - Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
  - Graduates of medical schools outside of the United States and Canada who meet requirements of the Medical Board of California for residency training and meet one of the following qualifications:
    - Current valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or
    - Full and unrestricted license to practice medicine in a U.S. licensing jurisdiction in which they are in training.
    - Graduates of medical schools outside of the United States who have completed a Fifth Pathway*program, provided by a LCME-accredited medical school, before they can start a residency program.

- Applicants to advanced levels of residency training must comply with the requirements for licensure by the Medical Board of California. American or Canadian Graduates who have had 24 months of residency training in an accredited training program anywhere in the United States or Canada must have a California Medical License in hand. International Graduates who have had 36 months of residency training in an accredited training program anywhere in the United States or Canada must have a California Medical License in hand.

Note:

A Fifth Pathway program is an academic year supervised clinical education provider by a LCME- accredited medical school to students who meet the follow conditions:

1) Have completed undergraduate premedical education in an accredited college or university in the United States that is of the quality acceptable to matriculation in a United States medical school.
2) Have studied at a medical school outside the United States or Canada listed in the World Health Organization Directory of Medical Schools.

3) Have completed all of the formal requirements of the foreign medical school except internship and/or social service.
4) Have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medicine Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).

Selection

Each residency program shall establish a process for selection of residents that is compatible with the following institutional requirements:

1. Applicants that meet the eligibility requirements will be considered on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.

2. The selection process will not consider gender, race, color, national origin, disability, or veteran status.

3. All applicants for PGY-1 positions are selected through the National Resident Matching Program (NRMP).

4. Applicants for programs that begin in the PGY-2 year or more advanced years for subspecialties should be selected through the NRMP or another appropriate organized matching program, if available.

Enrollment of Noneligibles

Residency programs will not enroll non-eligible physicians.

Number of Residents

The RRC will approve the number of residents enrolled in a program based upon the adequacy of resources for resident education including space, number of patients, and intensity of cases, quality and volume of patients and related clinical material available for education, faculty-resident ratio, institutional funding, and the quality of faculty teaching.

Resident Transfer

To determine the appropriate level of education for a resident who is transferring from another residency program, the program director receives written verification of the previous educational experiences and a statement regarding the performance evaluation of the transferring resident, including an assessment of proficiency in the six

(6) areas of competency, prior to acceptance to the program. A program director is required to provide verification of residency education for any residents who may leave the program prior to completion of their education.

Appointment of Fellows and Other Students

The appointment of fellows and other specialty residents or students will not dilute or detract from the educational opportunities of the regularly appointed specialty residents.

Duration of Appointment:

All resident and fellow appointments are one year in length.

Conditions for Reappointment:

Resident and fellow appointments are renewable annually on the recommendation of the Program Director and with the notification of the Associate Dean for Graduate medical Education. A decision not to reappoint will be based on the resident's performance, evaluations, and his/her ability to work and learn effectively within the residency program, as per the program's written policies.

Non-Renewal of Contract:

Programs must provide their residents with a written notice of intent not to renew a resident's contract no later than four months prior to the end of the resident's current contract. However, if the primary reason(s) for the non-renewal occur within the four-month" prior to the end of the contract, programs must provide their residents with as much written notice of the intent not to renew the contract as possible to allow the resident to implement the University Policy on Resident Grievance and Appeal Procedure.

Appointment

The Office of Graduated Medical Education and Department of Human Resources verify eligibility for appointment after the selection process.

	Status	Last	First	Dept	Year
ANESTHESIOLOGY					
	A	GHALY	RAMEZ	ANES	1
	A	WOOD	WENONAH	ANES	2
	A	MOVAHEDI	RANA	ANES	2
	A	EDWARD	RANIA	ANES	2
	A	GALINDO	GUILLERMO	ANES	2
	A	EHYA	NILOUFAR	ANES	3
	A	MAJEKODUNMI	ADETINUWE	ANES	3
	A	MCGINLEY	JENNIFER	ANES	3
	A	OJIMA	RICHARD	ANES	3
	A	WINDOKUN	ADEJARE	ANES	3
	A	JONES-BARNES	DELORIS	ANES	4
	A	KHOSHSAR	ROSTAM	ANES	4
	A	RICHARDSON	JOSEPH	ANES	4
	A	SONI	MONIKA	ANES	4
	A	TEKLE	ELSA	ANES	4
EMERGENCY MEDICINE					
1	N	ACHARYA	JANAK	EMER MED	1
2	N	AMINLARI	AMIR	EMER MED	1
8	N	DERDERIAN	HRAK	EMER MED	1
9	N	EIDENMULLER	WILLIAM	EMER MED	1
10	N	ENMON	CLEVELAND	EMER MED	1
11	N	FARRELL	ISAAC	EMER MED	1
12	N	GENDY	MARY	EMER MED	1
13	N	GENTILE	JASON	EMER MED	1
25	N	MAYNARD	MARY	EMER MED	1
22	N	KACHALIA	AMIT	EMER MED	1
20	N	JIMENEZ	AREN	EMER MED	1
16	N	GUTKIN	DAVID	EMER MED	1
6	N	CHIOU	AMY	EMER MED	1
4	N	BATES	MANDY	EMER MED	1
7	A	CRABB	JONATHAN	EMER MED	2
14	A	GHALILI	SAMAN	EMER MED	2
15	A	GIERAHN	ERIK	EMER MED	2
26	A	MCNEIL	NATHAN	EMER MED	2
27	A	NARIMATSU	SCOTT	EMER MED	2
28	A	NGUYEN	KHANH	EMER MED	2
29	A	NGUYEN	TRISH	EMER MED	2
39	A	THYMES	DEONZA	EMER MED	2
40	A	ZELTSER	LARISA	EMER MED	2
36	A	RUSHTON	JOHN	EMER MED	2
37	A	SCHULTZ	ERIC	EMER MED	2
33	A	REYES-FARINAS	PEDRO	EMER MED	2
3	A	AU-HARGRAVES	KATHERINE	EMER MED	2
5	A	CHEUK	VASCO	EMER MED	3
17	A	HAYATDAVOUDI	SAWSAWN	EMER MED	3
18	A	HINES	RYAN	EMER MED	3
19	A	HURLEY	JEFFERY	EMER MED	3
21	A	JONES	MICHAEL	EMER MED	3
23	A	KHUU	NGUYEN	EMER MED	3
24	A	LIGHTBURN	WINSTON	EMER MED	3

30	A	O'NEIL	TERENCE	EMER MED	3
31	A	RANGEL	JAVIER	EMER MED	3
32	A	REID	RICHARD	EMER MED	3
34	A	RODRIGUES	ALWYN	EMER MED	3
35	A	RUDD	ANTHONY	EMER MED	3
38	A	TAYLOR	MYIESHA	EMER MED	3
FAMILY MEDICINE					
16	N	BAIG	SHAHIDA	FAM MED	1
17	N	BANIGA	ULYSSES	FAM MED	1
18	N	BISHAY	BOLES	FAM MED	1
19	N	GOURABI	FARID	FAM MED	1
20	N	IRENE	SUNDAY	FAM MED	1
21	N	NAHEED	SANIYA	FAM MED	1
22	N	OM	TU	FAM MED	1
23	N	VICTOR	GINA	FAM MED	1
10	A	GOMEZ-MATTA	BEATRIZ	FAM MED	2
11	A	JIMENEZ	ANGELICA	FAM MED	2
12	A	KHAN	TAHIR	FAM MED	2
15	A	SAMEENA	ANJUM	FAM MED	2
13	A	LOPA	NASRIN	FAM MED	2
4	A	ALVAREZ-MARTINEZ	LILIANA	FAM MED	2
7	A	CEBALLOS	JECEBU	FAM MED	2
3	A	AKANDA	MAHFUJA	FAM MED	3
5	A	AZIZOLLAHI	FARID	FAM MED	3
6	A	CABRERA-FRANCISCO	MARIE	FAM MED	3
8	A	CERDA	GLORIA	FAM MED	3
9	A	FAHMI	SALWA	FAM MED	3
1	A	ACHALU	RADHA	FAM MED	3
14	**A**	**SAFVATI**	**SHAHRIAR**	**FAM MED**	**3/4**
24	**A**	**TERAN**	**LUCERO**	**FAM MED**	**3/4**
INTERNAL MEDICINE					
1	A	BEROOKIM	PEYTON	INT MED	3
2	A	BIRHAN	AMINU	INT MED	2
3	A	BORGHEI	ALI	INT MED	2
4	A	BRAR	PRABHJYOT	INT MED	3
5	A	CADOTTE	ROBERT	INT MED	3
6	A	DHAMIJA	RAJIV	INT MED	3
7	A	HAGHIGHAT	PEYMAN	INT MED	2
8	A	HLINE	SU	INT MED	3
9	A	HOU	WEI	INT MED	3
10	A	HTUN	PHYU	INT MED	2
11	A	KHAN-HUDSON	ALIA	INT MED	3
12	A	KOO	JOHN	INT MED	2
13	A	LEE	TE-IE	INT MED	3
14	A	MAHABADI	VAHID	INT MED	3
15	A	MEHTA	MANAN	INT MED	3
16	A	MORAGHEBI	PARDISE	INT MED	3
17	A	MYAT	THIN	INT MED	2
18	A	NYEIN	MAY	INT MED	2
19	A	OGBOGU	CHINELO	INT MED	3
20	**A**	**OVIEDO(LINARES)**	**RAUL**	**INT MED**	**5**
21	A	PETTERSEN	GABRIEL	INT MED	3

22	A	PIRA	MARIA ELAINE	INT MED	2
23	A	POUYA	PARMIS	INT MED	4
24	A	RHEEM	DAE	INT MED	1
25	A	RUBINSKY	STEVEN	INT MED	1
26	A	SETHEE	JAIANAND	INT MED	1
27	A	SONG	ZHIGANG	INT MED	1
28	A	VAIDYA	CHIRAG	INT MED	1
29	A	VINTHER	AMY	INT MED	1
30	A	WIN	MIN	INT MED	1
31	N	AKABIKE	NKIRUBA	INT MED	1
32	N	AUNG	LAI LAI	INT MED	1
33	N	AVENTURA	DIANA	INT MED	1
34	N	BRAR	MANDEEP	INT MED	1
35	N	HLA	TIN	INT MED	1
36	N	ILANI	NILOUFAT	INT MED	1
37	N	INFANTE	SERGIO	INT MED	1
38	N	FRANCOIS	EROLD	INT MED	1
39	N	JIMENEZ	GLORIA	INT MED	1
40	N	KASULA	PADMA	INT MED	1
41	N	KUMAR	NEELIMA	INT MED	1
42	N	LUI	LIDE	INT MED	1
43	N	NASR	NAHID	INT MED	1
44	N	PAXTON	DON	INT MED	1
45	N	SAN	KYI KYI	INT MED	1
46	N	SINGH	SHAILENDER	INT MED	1
47	N	TAWADROUS	ODETTE	INT MED	1
48	N	VIDAD	ALELI	INT MED	1
49	N	OO	THEIN	INT MED	2
50	N	TEE	GRACE	INT MED	2
51	N	ZEEDA	FARAH	INT MED	2
52	N	SINGH	SANDEEP	INT MED	3
53	A	KALANTARI	GITA	INT MED	1
CARDIOLOGY					
	A	KIM	GENE	INT MED/CARDIO	6
	A	NGUYEN	HAI	INT MED/CARDIO	6
DERMATOLOGY					
1	N	YUN	JUSTINE	INT MED/DERM	
2	A	HICKS-GRAHAM	SHARI	INT MED/DERM	3
3	N	BRIDGES	KHARI	INT MED/DERM	
4	A	NICHOLS	KIM	INT MED/DERM	2
5	A	SHABAZZ	DWANA	INT MED/DERM	2
6	A	YUN	JASMINE	INT MED/DERM	3
ENDOCRINOLOGY					
	A	CHOI	HOON-JI (HELEN)	INT MED/ENDO	5
	A	KATTA	PRASAD	INT MED/ENDO	5
	A	CALOF	OLGA	INT MED/ENDO	4
	A	ROY	RAJIV	INT MED/ENDO	4
GASTROENTEROLOGY					
	A	ANYADIKE	CYRIL	INT MED/GASTRO	5
	A	DEV	ANIL	INT MED/GASTRO	5
	A	TRAN	TAN	INT MED/GASTRO	7
GERIATRICS					

	A	HUA	PAUL	INT MED/GERI	4
	A	KHAN	HUMA	INT MED/GERI	4
	A	PHAM	KIMPHUONG	INT MED/GERI	4
	N	CHARUGUNDLA	GIRIJA	INT MED/GERI	4
	N	NWOSU	HILLARY	INT MED/GERI	4
	N	MERLO	ERNA	INT MED/GERI	4
	N	MILANES	ANTHONY	INT MED/GERI	4
	A	UDOKWU	ADAOBI	INT MED/GERI	4
INFECTIOUS DISEASES					
	A	HUYNH	CHARLES	INT MED/INF DIS	5
	A	MARER	STEPHEN	INT MED/INF DIS	4
	A	BAHMANI	PARVANEH	INT MED/NEPH	4
	A	ENENMOH	ANTHONY	INT MED/NEPH	4
	A	GUADIZ	RAMON	INT MED/NEPH	6
OB/GYN					
11	N	WILSON	BRANDYE	OB/GYN	1
12	N	GRIMES	MICHAEL	OB/GYN	1
13	N	KHALIFA	AHMAD	OB/GYN	1
3	A	GIRON-SOLANO	GUILLERMO	OB/GYN	2
1	A	AWANTANG-OLWENY	RUTH	OB/GYN	2
4	A	JESSIE	MARQUIS	OB/GYN	2
5	A	MARCELLO	ALTON	OB/GYN	2
7	A	MBA	HELENA	OB/GYN	3
2	A	EDMOND	REGINA	OB/GYN	3
14	A	WANG	FU NAN	OB/GYN	3
6	A	MAYELI	THOMAS	OB/GYN	4
8	A	MORADI	PARISSA	OB/GYN	4
9	A	SKINNER	GAYLE	OB/GYN	4
10	A	TAYLOR-HARRIS	DESHAWN	OB/GYN	4
ORAL & MAXILLOFACIAL SURGERY					
	A	CARDENAS	OMEL	OMFS	3
	A	FARR	FORREST	OMFS	2
	A	LUQUE	JUAN	OMFS	2
	A	IBE	AMAUCHE	OMFS	2
	A	PHAN	THOMAS	OMFS	2
	N	WILSON	TYLER	OMFS	2
	N	KARIMI	ALI	OMFS	2
	A	TAYLOR	KEITH	OMFS	3
GENERAL DENSTIRY					
1	**A**	**DUCKSWORTH**	**JOSEPH**	**GEN DENT**	**1**
2	**A**	**HUSSAINY**	**MIRWAIS**	**GEN DENT**	**1**
3	A	GUTIERREZ	YVETTE	GEN DENT	1
4	A	LA	JANET	GEN DENT	1
5	A	LERNER	TATIANA	GEN DENT	1
6	A	REYES	BELINDA	GEN DENT	1
7	A	MIERWA	ALEXIS	GEN DENT	1
OPHTHALMOLOGY					
	A	AZIMI	ASIF	OPHTH	4
	A	PEREZ	HUBERTO	OPHTH	3
	A	SOROUDI	ABRAHAM	OPHTH	4
	N	VASUDEV	PRIYA	OPHTH	

	N	LUVIANO	DAMIEN	OPHTH	
	A	UNZUETA	MIGUEL	OPHTH	3
ORTHOPEDIC SURGERY					
1	**N**	**BADY**	**SEPHR**	**ORTHO SURGERY**	
2	A	CHANNELL	KHALID	ORTHO SURGERY	5
3	A	CHEN	YOUGANG	ORTHO SURGERY	4
4	A	HARRISON	DANNY	ORTHO SURGERY	5
5	A	MOORE	DEREK	ORTHO SURGERY	3
6	A	QUESADA	MARIO	ORTHO SURGERY	3
7	A	SACOMAN	DAMEN	ORTHO SURGERY	5
8	N	GRANT	ANDRE	ORTHO SURGERY	
9	N	BADY	SEPHR	ORTHO SURGERY	
OTOLARYNOLOGY					
1	A	AVITIA	SOFIA	OTO	3
2	A	HAMILTON	JASON	OTO	5
3	A	REGALA	CHRISTOPHER	OTO	5
4	N	JEFFERSON	GINA	OTO	2
5	A	XU	XIAO-OU(HELEN)	OTO	4
PEDIATRICS					
10	N	GRANDSON	SHERRI	PEDS	1
11	N	MOBARAK	HAIDEH	PEDS	1
12	N	OHNMAR	KHIN	PEDS	1
13	N	SINGAL	SURESH	PEDS	1
14	N	TOTOIU	MINODORA	PEDS	1
15	N	VERDEFLOR	VINCENT	PEDS	1
16	N	WESTBROOKS	WENDY	PEDS	1
17	N	PALLAPATI	ARUNA	PEDS	1
18	N	HUSNG	KUN	PEDS	1
3	A	AJMAL	LUBAN	PEDS	1
8	N	DARVIN	LAARNI	PEDS	1
44	N	MONFARED	MARJAN	PEDS	1
9	A	GILL	JASMEET	PEDS	2
5	A	AZADI-RAD	AYAT	PEDS	2
6	A	BERMUDEZ-FRESSE	MARIA ISABEL	PEDS	2
2	A	AHSAN	NUSRAT	PEDS	2
36	A	SAN DIEGO	ROSITA	PEDS	2
37	A	TAPIA	GERTRUDES	PEDS	2
38	A	TATUNAY	HELEN	PEDS	2
40	A	TORRES	NOEL	PEDS	2
32	A	PIANSAY	MARIA	PEDS	2
29	A	OBENA	NANCY	PEDS	2
27	A	MEKIKYAN	ANNA	PEDS	2
20	A	HADDAD	ISSAC	PEDS	2
23	A	HASSAN-ELSAYED	AMINA	PEDS	2
25	A	IKE	IJEOMA	PEDS	3
26	A	MARIANO	HIPOLITO	PEDS	3
28	A	MOUSAVILAR	SHAMS	PEDS	3
30	A	OGELE	ANTHONIA	PEDS	3
33	A	PRIYADARSHI	ANAMIKA	PEDS	3
1	A	ADIVI	CHANDRA	PEDS	3
4	A	ALARCIO	MELANIE ANN	PEDS	3
34	A	QUEROL	CALEB	PEDS	3

43	A	KOWN	CLAUDIA	PEDS	3
22	A	HARBERT	GWENDOLYN	PEDS	3
19	A	GUCILATAR	MAX	PEDS	3
21	A	HAMAN	HANAN	PEDS/AMBULATORY	4
24	A	HUANG	HSIAO-CHUN	PEDS/CHIEF RESIDENT	4
35	A	RAHMAN	SHOWKOT	PEDS/AMBYLATORY	4
39	A	THOMPSON	FELITA	PEDS/CHIEF RESIDENT	4
41	A	ERINA	LIN	PEDS/ALLEGY-IMMU	4
31	A	PATEL	SONAL	PEDS/ALLERGY-IMMU	5
42	A	LILY	BONET	NEONATOLOGY	6
7	A	CASTRO	REYNEIRO	PEDS/ALLERGY	7
PSYCHIATRY					
19	N	AKPENYI	GEORGE	PSYCH	1
20	N	BROWN	AYANNA	PSYCH	1
21	N	DENNIS	TSHEKEDI	PSYCH	1
22	N	KIM	PETER	PSYCH	1
23	N	RICHARDSON	TERRI	PSYCH	1
24	N	RIZVI	SHARQAT	PSYCH	1
25	N	USMANI	TEHMINA	PSYCH	1
12	A	LU	JULIE	PSYCH	1
10	A	KHASHAYAR	SHAHIN	PSYCH	1
4	A	BRYANT	ONAIJA	PSYCH	1
5	A	CHIEN	LIAN	PSYCH	1
2	A	ANDERSON	LORI	PSYCH	1
16	A	SIDHOM	TAGHRID	PSYCH	2
17	A	SVOROVSKAIA	NATALIA	PSYCH	2
18	A	VAFAIE	JINOUS	PSYCH	2
19	A	WHITE, III	O.C.	PSYCH	2
8	A	JAMES	JOSEPH	PSYCH	2
9	A	KANG	XIN	PSYCH	2
14	A	MSHEWA	MARCIA	PSYCH	2
3	A	BOITOR	ILEANA	PSYCH	3
6	A	CORDERO-DARNELL	MARTHA	PSYCH	3
7	A	GOKHMAN	IZABELLA	PSYCH	3
11	A	KVICHKO	ELENA	PSYCH	3
13	A	LUCAS	DEBORAH	PSYCH	3
1	A	ANANIAS	PAUL	PSYCH	3
15	A	REDDY	DHANALAKSHIM	PSYCH	3